the appropriations process, I am satisfied with the overall bill. A lot of time and work by committee members and staff have been put into drafting the best bill possible that everyone can support.

Specifically, I am glad that S. 250 retains a separate authorization for the Tech Prep program. The House-passed bill eliminated this separate funding and during committee consideration of the bill, Representative TIERNEY and I offered an amendment to restore Tech Prep as a separate authorization.

Tech Prep creates seamless pathways for secondary students to transition into post-secondary education programs in the high-skill, high-wage technical fields. These academically and technically prepared graduates are critical to the economic growth, productivity and internal competitiveness of the United States. Knowing how critical this funding is to our local communities, I am pleased funding for the Tech Prep program has been kept separate from the Perkins block grant.

In addition to protecting Tech Prep, the conference report increases the role of math, science and technology in career and technical education programs and encourages the expanded use of technology by teachers and faculty. Increasing the emphasis given to science, technology, and mathematics is critical for the United States to retain its global competitiveness. We cannot afford to ignore growing competition from other countries by directing our resources away from these fields of study.

Again, I would like to thank all those in the education community who participated in reauthorization for their input and work on this bill. I am particularly pleased to acknowledge Dr. Bill Ihlenfeldt, President of the Chippewa Valley Technical College in Eau Claire, WI, who testified before the Education and the Workforce Committee in May of 2004. His thoughts and perspective on reauthorization of the Carl D. Perkins Career and Technical Education Improvement Act were invaluable in addressing the needs of our country. His insight was especially helpful in considering issues of importance for the 53,000 students attending technical schools in my district—Western Technical College, Chippewa Valley Technical College, and Southwest Tech—as well as the countless career and technical secondary students in the Third Congressional District of western Wisconsin. I urge my colleagues to vote yes.

Mr. CASTLE. Mr. Speaker, I yield back the balance of my time.

The SPEAKER pro tempore. Without objection, the previous question is ordered on the conference report.

There was no objection.

The SPEAKER pro tempore. The question is on the conference report.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Mr. CASTLE. Mr. Speaker, I object to the vote on the ground that a quorum is not present and make the point of order that a quorum is not present.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, further proceedings on this question will be postponed.

The point of no quorum is considered withdrawn.

GENERAL LEAVE

Mr. BARTON of Texas. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks and insert extraneous material on H.R. 4157.

The SPEAKER pro tempore (Mr. CASTLE). Is there objection to the request of the gentleman from Texas?

There was no objection.

HEALTH INFORMATION TECHNOLOGY PROMOTION ACT OF 2006

The SPEAKER pro tempore. Pursuant to House Resolution 952 and rule XVIII, the Chair declares the House in the Committee of the Whole House on the State of the Union for the consideration of the bill, H.R. 4157.

□ 1311

IN THE COMMITTEE OF THE WHOLE

Accordingly, the House resolved itself into the Committee of the Whole House on the State of the Union for the consideration of the bill (H.R. 4157) to amend the Social Security Act to encourage the dissemination, security, confidentiality, and usefulness of health information technology, with Mr. SIMPSON in the chair.

The Clerk read the title of the bill.

The CHAIRMAN. Pursuant to the rule, the bill is considered read the first time.

General debate shall not exceed 1 hour, with 35 minutes equally divided and controlled by the chairman and ranking minority member of the Committee on Energy and Commerce, and 25 minutes equally divided and controlled by the chairman and ranking minority member of the Committee on Ways and Means.

The gentleman from Texas (Mr. BARTON) and the gentleman from New Jersey (Mr. PALLONE) each will control 17½ minutes, and the gentlewoman from Connecticut (Mrs. JOHNSON) and the gentleman from California (Mr. STARK) each will control 12½ minutes.

The Chair recognizes the gentleman from Texas.

Mr. BARTON of Texas. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, I am pleased that the House today is going to consider H.R. 4157, the Health Information Technology Promotion Act of 2006. This legislation should help move our health care system into the modern era and the modern information age.

We all remember a time when e-mail was a dream and getting the legislative text from the House of Representatives Web site was impossible because it simply did not exist. As information systems have moved into the digital age, Congress and most of the private sector have embraced it. We have found that we could get information much more efficiently and quickly at much less cost.

The health care system, for whatever reason, has not done that. For all of its medical genius and astonishing technology in terms of surgery and orthopedics and diagnosis, American health care is still stuck back in the 19th century, with a paper record system that is inefficient, wasteful, error-prone and occasionally dangerous. The legislation before us today should change that.

With H.R. 4157, records that have been stuffed in a file cabinet and illegible prescriptions that nobody can read scrawled on pieces of paper will finally give way to digital medical records, electronic prescribing, and efficient coordination of care. Sick patients will get better and everybody should save money.

The bill before us sets out a framework for endorsing core interoperability guidelines and mandates compliance for a Federal information system within 3 years of endorsement of such guidelines. Of vital importance are provisions contained in the legislation that create safe harbors to the Stark and Anti-kickback laws for the provision of health information technology and services to better coordinate care between hospitals and providers. These changes are long overdue.

Hospitals and other health care entities that have invested in systems that are tested and work well should be able to share their experience and purchasing power with physicians. Current laws have prevented these reasonable steps to better coordinate patient care by not allowing the sharing of health information technology systems.

Also, I would like to express support for the Secretary of Health and Human Services to look at the list of entities that we make eligible for this safe harbor and to expand upon it, specifically, to include independent clinical laboratories which carry a great deal of health data that should be shared electronically.

□ 1315

These safe harbors will allow for economical sharing of health information technology to better coordinate care, reduce medical error, and improve patient outcomes.

Medical science in recent years has produced tremendous discoveries that have revolutionized how we treat disease and care for patients. Unfortunately, the medical record information technologies needed to take advantage of these discoveries remain locked in an era of paper and filing cabinets. We can do better, and the legislation before us today will do better.

Mr. Chairman, I reserve the balance of my time.

Mr. PALLONE. Mr. Chairman, I yield myself 3 minutes.

Our Nation's health care system is arguably the most inefficient and costly system in the industrialized world. We spend approximately $1.7 billion annually on health care, and yet many of our citizens are in poorer health than the citizens of countries that spend far less. That is because our Nation's health care system is wrought with

problems, including skyrocketing costs that make it difficult for Americans to afford the care that they need, inconsistent quality, and huge disparities in care and access. Clearly, the status quo is not working and something has to be done to fix these problems. Health care experts around the country agree that health information technology, or HIT, could provide a partial solution to our problems.

Now, while estimates vary, the potential savings from HIT could reach between $81 billion and $170 billion annually by improving coordination of care, patient safety, disease management, and prevention efforts. Under the Republican bill we are debating today, however, none of these savings will be realized. That is because the bill will do nothing to move our Nation forward on health information technology.

The CBO agrees with the Democrats, and I quote, ''CBO estimates that enacting H.R. 4157 would not significantly affect either the rate at which the use of health technology will grow or how well that technology will be designed and implemented.'' So I don't want anybody to be fooled here today. Don't let the Republicans sell you this lemon.

My friends on the other side of the aisle would have us believe that this bill is going to transform our health care system into a model of efficiency, and it is all a bunch of hype. Let me mention a few ways in which this bill is flawed.

First of all, there is virtually no funding, and I stress that, virtually no funding to help providers, such as physicians or hospitals, to purchase this technology. The meager amount of funding authorized in this bill will barely make a dent in advancing the use of HIT. Instead of making grants or loans available to doctors to help them purchase equipment or train employees, Republicans have decided to roll back anti-kickback and self-referral protections so that doctors will have to rely on other types of providers for this technology. Make no mistake about it, this is going to open the door for fraud and abuse to run rampant and will eventually add to our health care costs.

Secondly, this bill does nothing to improve protections for medical privacy. Electronic health information systems that make it easier to exchange medical information require new privacy protections to be implemented and strongly enforced. In spite of the privacy breaches we saw this year at the Veterans Administration, and also at CMS, Republicans don't seem to think there is a need to strengthen our Nation's privacy laws. But I have to tell you, Americans are not going to stand for this. They are not going to want their most personal information floating around cyberspace without any reasonable safeguards.

There are a number of other problems with this bill, Mr. Chairman, but let me finally talk about the process in which this bill was developed. House Republicans have taken an opportunity for all of us to work together on an important issue and they have squandered it. The Senate was able to pass a bipartisan bill that would accomplish a lot more than the bill we are debating today. They authorize grants and loans, they don't roll back fraud and abuse protections, and they ensure interoperability. But they did this all on a bipartisan basis in the Senate.

Democrats in the House tried to offer that bill as a substitute in the Rules Committee yesterday, but we were denied the substitute. And it is a shame that House Republicans couldn't follow the Senate's lead and work with Democrats to move our Nation forward on HIT and improve the health of all Americans.

I urge my colleagues to vote ''no'' on this bill, because although we think that health information technology is very important, this bill will not accomplish the goal.

Mr. Chairman, I reserve the balance of my time.

PARLIAMENTARY INQUIRY

Mr. BARTON of Texas. Parliamentary inquiry, Mr. Chairman.

The CHAIRMAN. The gentleman will state his inquiry.

Mr. BARTON of Texas. Mr. Chairman, how is time going to be rotated? Do we do all the Energy and Commerce time and then the Ways and Means time; or do we rotate in sequence?

The CHAIRMAN. The Chair would accommodate the wishes of the managers.

Mr. BARTON of Texas. Okay. Congresswoman JOHNSON says the Energy and Commerce Committee goes first.

Mr. PALLONE. I think, Mr. Chairman, we were told in advance that we would do Energy and Commerce first, so that is the way we would prefer to proceed.

Mr. BARTON of Texas. Okay. That is what Congresswoman JOHNSON also says. I was not informed of that.

Mr. Chairman, I yield 3 minutes to a distinguished physician member of the Committee on Energy and Commerce, Dr. MURPHY of Pennsylvania.

Mr. MURPHY. I thank the chairman and the Members for an opportunity to talk about this vitally important bill.

Years ago, when I was working at Children's Hospital in Pittsburgh, I happened to be walking by the emergency room when a resident called me urgently in on a case that was there. It was a child who was having out-of-control behavior, rapid heart rate, rapid breathing, and she merely commented that this child's behavior was out of control. That could have been a symptom of anything. Was the child having a seizure? Was the child poisoned? Was the child having a drug problem, a neurological crisis, a heart problem, or a whole host of issues?

As it was, I happened to recognize the child as a patient of mine and we quickly came to the conclusion that one of the aspects may be a medication overdose, or a bad medication reaction. The parents had not yet arrived and we had not yet accessed his medical records. Why? Because the medical records were in a file somewhere back in my office in another section of the hospital and were ones that the emergency room staff could not acquire.

Think of this, too. If one of us, any of us, any American is traveling in a town somewhere in America and a medical crisis hits them, for someone who is diabetic or perhaps has heart disease or some other problems, where do we get the records to determine what to do? It is for this reason that we recognize about $162 billion a year is lost in health care, according to the RAND Corporation, and you include all the other paperwork and problems that come with hospital care, perhaps $290 plus billion is spent on that. Why? Because of medical records.

The current medical records system is this: Room after room after room in a hospital filled with paper files. What happens if we move to electronic medical records where it is, instead of here, it is in a computer? This is what that room looks like. It is now in a computer, accessible to physicians in a hospital, with pass codes and access codes that keep it secure, because HIPAA laws say it must be secure; that people can't have that, and then it becomes records that look more like this.

Again, a doctor with clear authorization ahead of time could find a patient's name, see their status, see what is going on, and move towards that and pull these records out. Otherwise, you end up in a situation of medical crisis. Patients can carry this information in a credit card or on a zip drive they can carry on their key chain. All this is critically important because it saves lives and saves money.

The best doctors and the best hospitals in America, if they cannot get the patient information they need when they need it, it can lead to morbid consequences: Higher mortality. And that is what ultimately this bill is about. This is a huge step forward because we have to have standards and other things moving forward. Hospitals all across America are moving towards some level of electronic medical records. But if we don't find ways of making them able to talk to each other, with uniform standards, interoperability, et cetera, we are essentially creating a medical Tower of Babel. We have more information, but they can't talk to each other.

At that moment of crisis in a health care center, whatever that is, whether you are at home or far away, no matter how good your doctor and hospital is, you want them to have that information. Patients can preauthorize that information. They can carry that with them. But this is the new technology, and if we don't do this, we will see many lives lost, and that is something we cannot afford to do. That is why I urge the passage of this bill.

Mr. PALLONE. Mr. Chairman, I yield 3 minutes to the gentleman from California (Mr. WAXMAN).

Mr. WAXMAN. Mr. Chairman, we should not pass H.R. 4157 without including essential privacy protections for the health information of American consumers. Privacy protection should go hand-in-hand with efforts to promote health information technology, yet the Republican leadership refused to include appropriate privacy protections or allow consideration of privacy amendments.

Our health care system will not be effective if privacy fears deter Americans from seeking appropriate treatment. Unfortunately, survey after survey demonstrates that American consumers lack confidence that the privacy of their personal health information will be protected.

Just last year, the California Health Care Foundation found that nearly two-thirds of Americans polled were concerned about the privacy of their health information, and one out of eight had taken steps that could have put their health at risk simply because of privacy concerns. Moving health records into electronic form is only likely to increase their fears unless we act to ensure appropriate privacy protections are in place.

Recent incidents involving security threats to medical information have underscored the vulnerability of electronically maintained data. In June, we learned that Medicare data on 17,000 beneficiaries enrolled in a Medicare prescription drug plan had been put at risk due to inappropriate security protections on a computer file. And then the Department of Veterans Affairs' computer that was stolen several months ago contained sensitive information that included disability ratings for some veterans and notes about some veterans' health conditions.

In fact, according to the Privacy Rights Clearinghouse, nearly 90 million electronic data records of U.S. residents have been compromised because of security breaches in just the past year and a half.

This administration's lax approach to enforcing existing medical privacy requirements has raised additional concerns. A recent Washington Post article reported that the administration has not imposed a single civil fine under the Federal medical privacy rule despite nearly 20,000 complaints of violations over the 3 years the rule has been in effect.

It is irresponsible for Congress to promote the development and use of health information technology without ensuring that necessary privacy and security for health information are in place.

I thank the gentleman from New Jersey for yielding to me so I could point out these specific concerns that I have with this legislation, and I wish we could address them.

Mr. BARTON of Texas. Mr. Chairman, I yield myself 30 seconds before I yield to Mr. CASTLE.

Under the current law, called HIPAA, we have very strict privacy protection guidelines. Those guidelines are currently under review. There have been over 50,000 comments filed with HHS for some proposed changes in those. Nothing in the Senate bill, that is a companion bill to this bill, deals with privacy.

Privacy is an important issue, but more important is that we get a health information system technology in place, and that is what this bill does.

Mr. Chairman, I yield 2 minutes to the former Governor of the First State, the great State of Delaware (Mr. CASTLE).

Mr. CASTLE. Mr. Chairman, I would like to thank Chairman BARTON for yielding, but I also want to thank him for his great work on this important legislation, H.R. 4157, which I support; and also the gentlewoman from Connecticut (Mrs. JOHNSON) has worked on this for some time, and will be speaking shortly.

With recent reports estimating that medical errors may be responsible for up to 98,000 deaths and 1.5 million medication errors each year, there is no doubt in my mind that the time has come to move towards an electronic health records system.

I am pleased this legislation officially establishes the Office of the National Coordinator for Health Information Technology, because it is absolutely vital that the Federal Government take the leading role in establishing such a system. Without a strategic Federal plan, I worry that each State will be left to their own devices and we will end up with a patchwork system. I am hopeful that the standards which are set will be easily adaptable for the States and regions that are already working on such connectivity.

In my State of Delaware, we have established the Delaware Health Information Network. It has secured a $4 million contract with the Agency for Health Care Research and Quality to establish an e-health system in our hospitals, physicians' offices, and laboratories. Eventually, we hope this will be extended to our nursing homes and community health centers as well.

Because Delaware is such a small State, it is quite possible that our network can spread across the Mid-Atlantic region to include New Jersey, Pennsylvania, and Maryland, and that is why we have been working so hard to get it right and to make sure interoperability truly exists.

A national health electronic infrastructure could truly be lifesaving for the millions of patients who access our health care system every day, as we have seen in our VA hospitals. There is real opportunity here to have electronic patient records, with appropriate private protections, electronic prescribing, real-time understanding of prescription interactions, and improved outcomes.

I am hopeful this bill will be swiftly conferenced with the Senate version so every State may get involved. Real achievement only comes when we improve health care, reduce costs, and start saving lives.

Mr. PALLONE. Mr. Chairman, I yield 2 minutes to the gentleman from Texas (Mr. GREEN).

(Mr. GENE GREEN of Texas asked and was given permission to revise and extend his remarks.)

Mr. GENE GREEN of Texas. Mr. Chairman, I rise in opposition to the Health Information Technology Promotion Act. Health IT, as we call it, has the potential to revolutionize our health care system by improving health outcomes through increased efficiency and accuracy. Despite the bill's title, however, this legislation would do little to actually promote the adoption of health IT among the providers who would most benefit from it.

Most importantly, the bill fails to include adequate funding to help providers invest in this promising technology. The $30 million in grant funding is only a drop in the bucket, so to speak, and will be stretched thin among the many providers who need financial assistance with health IT adoption.

□ 1330

Unfortunately, the Rules Committee failed to make in order either the Dingell/Rangel substitute or my amendment, which would have gone a long way to facilitating widespread health IT adoption. Specific to my amendment, which I submitted with my colleagues on our committee, Mr. GONZALEZ and Mr. RUSH, would authorize a Medicare add-on payment, a competitive grant and a State loan program to help providers invest in this technology.

If health IT is a priority of the Federal Government, then we need to put our money where our mouth is.

The bill is also sorely lacking in privacy protections. If patients are going to buy in to the benefits of health IT, we must ensure that personal health information is as secure as possible.

We already know from nationwide surveys that two-thirds of Americans are concerned about security of their personal health information.

The very nature of health IT is at risk of privacy breach; therefore, the proliferation of health IT must be accompanied by increased privacy protections.

Unfortunately the Rules Committee failed to allow the Markey/Capps amendment to be considered. That important amendment would have required patient consent before their health records were shared, as well as patient notification in the event of a privacy breach. This commonsense amendment would have closed a glaring loophole that we currently have in HIPAA.

In doing so, it would have given patients the privacy assurance they need to share important health information and to maximize the benefits of health IT to their personal health.

It is not often I advocate that the House should follow the Senate's lead, however, we should have better served our constituents if we take up the Senate bill.

Passed unanimously by the Senate, that bipartisan health IT bill will provide the necessary resources and pave the way for Americans to benefit from the promised health IT.

I encourage my colleagues to vote against this bill.

Mr. BARTON of Texas. Mr. Chairman, I yield 2 minutes to another distinguished member of the Energy and Commerce Committee, who is also a medical physician, Dr. BURGESS of Texas.

Mr. BURGESS. Mr. Chairman, thank you for bringing this important bill to the floor.

The bill, 4157, will codify and expand the authorities and duties of the office of the National Coordinator for Health Information Technology, Department of Health and Human Services. This includes a number of responsibilities, such as endorsing the interoperability guidelines under a schedule, conducting a national survey on the information exchange capabilities of certain entities, and reviewing Federal information systems and security practices.

The bill requires that certain Federal health information collection systems be capable of receiving information in a form consistent with any guidelines endorsed by the National Coordinator, within 3 years of endorsement.

We have heard some discussion about the issues of grants. Currently there are grants through both CMS and my own Texas medical foundation back in Texas. But indeed, this bill authorizes targeted grants to help integrated health systems relay information and better coordinate the delivery of care for uninsured, under insured and medically underserved populations.

The bill also contains a demonstration program to promote the adoption of health IT in the small physician setting, absolutely critical in many of our rural markets.

My colleague, Dr. MURPHY, was up here a moment ago and showed a picture of a medical record, an old paper medical records system in a hospital. I actually want to tell you that that is pretty far from the truth. Normally you go in medical records department, it is nowhere near that clean. There are records stacked on the floor. They are stacked by dictation machines. Oftentimes a critical record is hard to find.

But contrast that with what I saw in New Orleans, Louisiana when we had a hearing down there earlier this year. The records room of Charity Hospital is absolute chaos. There is still water on the floor. There are records all over that room. There is black mold growing up the sides of the records. Clearly, those records are unusable in any form or any hope to be usable in the future. That is why this legislation is so critical. Lives, as well as money and time can be saved if we make these important steps towards enacting this legislation.

Mr. PALLONE. Mr. Chairman, I yield 4 minutes to our ranking member of the full committee, the gentleman from Michigan (Mr. DINGELL).

(Mr. DINGELL asked and was given permission to revise and extend his remarks.)

Mr. DINGELL. Well, Mr. Chairman, here we are again. Bad legislation, bad procedure, unfair behavior by the majority, and the inability to have a proper discussion of the matter before us or to have an honest chance to amend a bad bill.

My Republican colleagues are wasting a fine opportunity to make real progress in an area in which most Members of Congress are highly supportive, health information technology. We have a chance not only to save money and time, but we also have a chance to save lives. But we won't even allow a proper discussion or fair and decent amendments.

We have a chance to help providers to transform their practices so that they could better serve the needs of their patients and so that there could be electronic communications with providers, health plans and with the government.

The Democrats sought a substitute to the committee bill under the rules. The Rules Committee, as usual, rejected it. So we are functioning under a gag rule. This alternative was identical to the bill the Senate passed unanimously last November with strong privacy protections, and with bipartisan sponsorship and support. The Senate bill, S. 1418, was jointly introduced after being negotiated between Senators FRIST, CLINTON, ENZI and KENNEDY. But we won't be permitted to vote on it today. We must hear from our Republicans as to why it is they are afraid to allow proper debate, or why it is that they won't allow a proper vote on matters which could strongly, broadly and importantly affect their constituents and mine.

The bill before us falls short. First, it makes no progress towards protecting the privacy and security of health information. Expanded use of electronic health care systems clearly has a great potential benefit, but it also poses serious threats to patients' privacy by creating greater amounts of personal information susceptible to thieves, rascals, rogues and unauthorized users.

President Bush said something to my Republican colleagues, and I hope every once in a while they listen to their leader. He said this: ''I presume I am like most Americans. I think my medical records should be private. I don't want people prying into them. I don't want people looking at them. I don't want people opening them up unless I say it's fine for you to do so.''

Well, why is it that you won't protect, then, the records of people and share the concerns of the President?

Second, H.R. 4157 fails to include sufficient Federal funding to foster the adoption and implementation of health information technology such as electronic medical records. Start-up costs are a very significant failure and a barrier that physicians face.

Third, H.R. 4157 goes too far in undermining fraud and abuse laws as its response to needed investment. The exceptions provided in this bill to the Stark self-referral and anti-kickback statutes potentially encourage biased decision making about a patient's treatment, and it sets up a situation where a doctor may be compelled to be confined in a system run by a particular hospital or health care provider.

Fourth, the bill falls short in establishing comprehensive standards. It does little or nothing to promote the adoption of standards by providers. The fastest way to accomplish this would be to have the Federal Government to abide by the standards that it adopts for electronic communications so that others in the private sector will follow. H.R. 4157 does none of this.

The bill fails seriously on issues of patient privacy, funding for health information technology, providing and promoting electronic communications between providers, and protecting against fraud. This is a bad bill. A chance to write good law has been rejected. The bill should be rejected, and I urge my colleagues to vote ''no.''

Mr. BARTON of Texas. Mr. Chairman, I yield 2 minutes to the Vice Chairman of the Energy and Commerce Committee, the brightest bloom to come out of Laurel, Mississippi, CHIP PICKERING.

Mr. PICKERING. Mr. Chairman, I rise today in support of very significant legislation. Too often in this place we are faced with dilemmas and difficult choices of trying to find savings that could diminish care, the quality of care, the availability, the accessibility of care. But this is actually an opportunity for us, in this Chamber, and as we go through the legislative process in the House and the Senate, to have significant savings to allow a stronger, more sustainable Medicare Medicaid health care system, that instead of reducing the quality of care, improves the quality of care, reduces errors and improves the efficiency of how health care is delivered. This is a great opportunity and it should be an opportunity of bipartisan support. I do believe that when we get to the final product, that when we finish the House and the Senate conference, that this is something where we can have broad consensus. We do not necessarily need partisan division on something that has such great promise and potential to save money, the resources that we so desperately need in our health care system, but, more importantly, to protect and promote and to heal the individuals and the lives across the country.

Just coming out of Katrina, we have seen in hospitals and health clinics and community health centers across Mississippi, the loss of medical records. If

we have electronic records in place, that will not happen in future storms. This is a critical protection to the records which are vital to the health care of our citizens. Those that are poor and low income, electronic records in community health centers and in Medicaid systems and in VA systems have seen and will see tremendous benefits. This is an area in health care policy where we should not be divided, where we should find agreement, and we should accomplish good things together.

Mr. Chairman, I support this legislation, and thank you for your leadership on this issue.

Mr. PALLONE. Mr. Chairman, I yield 2 minutes to the gentleman from Illinois (Mr. RUSH).

Mr. RUSH. Mr. Chairman, I was disappointed with this bill during the mark-up in the Energy and Commerce Committee, and I remain disappointed with the final version on the floor today. With information technology, this Congress has an opportunity to revolutionize the way health care is delivered in this country, but this bill is weak and it merely props up the status quo. And, Mr. Chairman, this bill could actually make things worse.

My main concern is that underserved communities would not be a part of the health care information technology revolution. Too often communities such as those I represent where a disproportionate number are minority Americans and are the last to garner the benefits of new technological developments. As such, it is vital that any serious HIT bill have a funding component that aids low income providers. Unfortunately, this bill does virtually nothing to address this very serious problem.

Nor does this bill have adequate requirements for interoperability which is, of course, a very huge flaw. Many low-income residents in densely populated urban environments do not have a primary care doctor that serves as a consistent medical provider. Instead, these citizens often go from provider to provider, from clinic to clinic, and receive their health care only sporadically. As such, it is vital that all of these providers are connected to interoperable information systems, such that they are all able to communicate with each other and share necessary medical information. Without interoperability requirements, we are left with the possibility of a network of fragmented health care delivery systems that are not able to talk to each other and coordinate care.

Mr. Chairman, I must oppose this bill, and I urge my colleagues to oppose it also.

Mr. BARTON of Texas. Mr. Chairman, I yield 2 minutes to a distinguished congressman from the Pelican State of Louisiana, who is a cardiovascular surgeon, Dr. BOUSTANY.

Mr. BOUSTANY. Mr. Chairman, during my career as a cardiovascular surgeon, I saw far too many nurses, physicians and patients waste valuable time on paperwork. And I saw situations where available critical information was not available during a crisis.

Immediately following Hurricane Katrina and Rita, the need for portable electronic medical records became undeniable when thousands of patients' records were destroyed or inaccessible. But we did see some hope in that the New Orleans VA Hospital, despite being flooded, had records for 50,000 patients that survived because of the electronic nature of the records and the backup system that was available.

We also saw a secure Web site, Katrinahealth.org, established through a private/public partnership that was another promising example.

□ 1345

When it comes to the use of information technology, America's health care sector has lagged far behind other economic sectors for decades. Our inefficiencies also squander billions of health care dollars that could otherwise go to helping patients.

This legislation pending before the House today is critical. It will help overcome one of the most significant barriers to the adoption of health IT. Small physician practices find it financially difficult to invest in health IT equipment. The investment can run as high as $120,000 per physician. Federal statutes currently make it illegal for these providers to accept this equipment from a hospital or an insurance partner. To address this problem, this bill would provide the adequate safe harbor so that organizations could donate equipment to physicians without violating law.

H.R. 4157 will help empower patients. It does preserve State privacy laws. It limits skyrocketing costs. And it will improve quality. Failure to modernize our health system is simply unacceptable, particularly given the aging population, the rising health care costs, and the prospects of future natural disasters.

So I urge passage of this very important legislation.

Mr. PALLONE. Mr. Chairman, I yield 2 minutes to the gentlewoman from California (Mrs. CAPPS).

Mrs. CAPPS. Mr. Chairman, I thank my colleague for yielding.

I rise in strong opposition to H.R. 4157. Rather than move our health care system into the 21st century, this bill does little other than bestow gifts upon the insurance companies and big businesses. HIT does have great promise, great opportunity. And as a nurse, I know very well the importance, for example, of electronic medical records. But if the leadership was really serious about facilitating wider-spread adoption of HIT that is able to deliver better quality health care for patients, this bill would have contained the following:

A timeline for achieving interoperability; funding so that hospitals and physicians could afford to purchase the technology; and, as I mentioned when I spoke against the rule, privacy protections. What good is health information technology if providers cannot communicate with each? What good is the existence of health IT if nobody can afford to use it? And what good is making our personal, private, sensitive information vulnerable to improper access and disclosure?

Unfortunately, we are still in an age where individuals may be discriminated against because of health conditions. Here is our chance in a bill to protect personal information from being used to discriminate against people. And my colleagues on the other side of the aisle have indicated they do not care about patients' rights to privacy. If you look carefully at the organizations supporting privacy protections, you will notice they are patient advocates, consumer groups, health professionals.

Those opposing it? The industry.

Whom are we passing this bill for today? I thought it was supposed to be for patients so that they could receive better care and for the health professionals so they could provide better care. But it is clear to me that this bill before us disregards patients' needs.

We need to start over and do a better job. HIT is that important. But not this bill. I, therefore, oppose H.R. 4157 and urge my colleagues to vote ''no.''

Mr. BARTON of Texas. Mr. Chairman, I yield 2 minutes to a member of the committee, the distinguished majority whip from the Show-Me State of Missouri, the Honorable Mr. BLUNT.

Mr. BLUNT. Mr. Chairman, I thank Chairman BARTON for yielding and for bringing this bill to the floor.

The chairman and members of our committee, particularly Mrs. JOHNSON from Connecticut on the Ways and Means Committee, have been so instrumental in getting this bill to the floor today. This is a critically important start.

As I sat here and listened to the debate, it is clearly like we are debating two different bills: one that wants to change the entire world in one bill and one that wants to step forward.

On the privacy issue, this does not do anything to change current privacy standards, but what it does is allow the information that people have about their health to be shared in a way that helps them. And in terms of the cost, taxpayers pay an awful lot of the health care cost in the country today. And as my good friend Mr. PICKERING pointed out, this is a way to minimize cost and maximize benefits to patients at the same time. That does not happen very often.

Mr. Chairman, we have a little town in my district, Branson, Missouri, and it has lots of tourists. Seven or eight million people come there ever year. Last year, last August, I was sitting at lunch beside the hospital administrator, and he shared with me that particularly in about the fall, most of the tourists that come are retired. Many of

them come as part of a package travel situation. And he said, If you are retired and you paid for a package travel, if you feel like getting on the bus, getting on the airplane, you more often than not make an effort to make that trip, and more times than you would expect, the first stop on that trip is the hospital. For somebody who is on that motor coach who should not have probably gotten on but they get to Branson, Missouri, not feeling all that well, with the right kind of ability to get their health information shared, a 3-day visit to the hospital could be a 3-hour visit to the hospital.

We need to start this process. Chairman BARTON understands that. Mrs. JOHNSON understands that. Our committee understands that. This is the way to do it today. I am pleased to see this bill on the floor. It is an important first step. You can never get there if you do not take the first step. This is a great first step.

And, Chairman BARTON, I applaud your efforts to get this bill on the floor.

Mr. PALLONE. Mr. Chairman, I yield myself the balance of my time.

Mr. Chairman, I just wanted to say, from personal experience in my home State of New Jersey over the last few months, I have visited a number of hospitals throughout the State and looked at their health IT, and I have also talked to a number of physicians. The reason that this legislation is not going to accomplish the goal of really expanding health IT, and I can tell just from my experiences with these hospitals, first of all, most of the doctors say that even for a small group practice, they probably have to invest about $50,000 or more into health IT. And given the reimbursement rates and what is happening right now, most physicians, particularly small group physicians in rural areas and in urban areas, are not able to make that kind of investment. So that is why we need a funding source.

This bill has very little funding, minimal. And the substitute, which is based on the Senate bill, on a bipartisan basis, would provide the funding to make a meaningful difference so that we would have an increase in health IT. That is what this is all about. That is why we should reject this bill and adopt something like the Senate bill.

In addition, with regard to the privacy provisions, when I visited the hospitals in New Jersey, it was very clear to me that when you start to move with a lot of these electronic and high-tech systems, there is going to be a real problem with privacy that may not exist now with traditional systems. Moving to an electronic system, you have to have additional privacy guarantees. And we feel, again, the Democratic substitute that was rejected by the Rules Committee had those privacy guarantees. I think they are going to be part of our motion to recommit.

This is the time to address the privacy issue in the context of this bill, and I would ask that we reject the legislation.

Mr. BARTON of Texas. Mr. Chairman, before I yield to Congressman CLAY of Missouri, let me compliment Subcommittee Chairman DEAL for his efforts on this bill. He cannot be here today because his mother is ill, but he worked very hard.

Mr. Chairman, I yield 1 minute to the distinguished congressman from Missouri (Mr. CLAY).

Mr. CLAY. Mr. Chairman, I thank the gentleman for yielding.

Mr. Chairman, I rise today in support of H.R. 4157, the Health Information Technology Promotion Act of 2006. I believe the bill before us is a thoughtful and measured approach for establishing the Federal Government's role in promoting the adoption of a national health information network.

The bill before us takes the logical step of codifying the Office of the National Coordinator for Health IT at HHS. This will ensure long-term stability and continuity in the establishment of policies and programs relating to network interoperability, product certification, and adoption throughout the health care stakeholder community. It will also prove beneficial to both providers and public health agencies nationwide as vital clinical, prescribing, and laboratory information will be accessible through one integrated network.

I want to thank Congresswoman JOHNSON and Congressman DEAL for their good work.

Mrs. JOHNSON of Connecticut. Mr. Chairman, I yield myself 5 minutes.

I rise in strong support of the legislation and would submit my opening statement for the RECORD.

I would like to comment on some of the comments of my colleagues made earlier. Before I do that, let me just take a moment to thank Chairman BARTON and Representative NATHAN DEAL and my own chairman, Chairman BILL THOMAS, for their support and effort in the development of this bill. But instead of doing my opening statement, let me comment on some of the things that have been said to this point.

First of all, on the issue of privacy, this bill sets the groundwork to improve privacy by putting in place a study of State privacy laws and Federal privacy laws so we can see what is working, what is not working, how similar are the State laws, where might their differences inhibit the security of a nationwide system. In other words, it gives us the knowledge we need to upgrade our HIPAA system if, indeed, that is necessary. It may tell us that is not necessary. But it would be absolutely irresponsible to move ahead without the information that will be developed as a result of this legislation. HIPAA already provides absolute protection of our health information.

What we want to know is when you do what this bill envisions, that is, you create a nationwide interoperable health information system to put that in place and secure personal health data, are there changes you need to make in Federal law? Are there commonalities in State laws that need to be brought closer? Are there any changes, indeed, that need to be made to absolutely secure individual personal health data as we move to this system? That is the issue on privacy.

Secondly, this bill adopts a whole new coding system, the ICD–10 system. Under today's system, you cannot tell whether a hospital has made a great leap forward in quality because they are doing a better job or simply because they have changed an operative technique from an invasive operation to a noninvasive approach to that surgical procedure. So we have to know more about what we are doing so we can talk honestly to ourselves about quality, so we can upgrade quality, and so we can pay accurately. This bill does that.

This bill sets up an Office of Technology, and we need that office to assure that the public and private sectors work together to create an environment in which great companies in America compete to provide the best possible technology, all of which becomes interoperable.

So without a Federal office involved, without standards being set, we will not have that interoperable system that we know is going to be so important to improve the quality of our health care system.

Not only do we need to have standards; we need to accelerate dissemination because the power of health information technology is not in a single provider. It is in the system-wide impact of it. So this bill helps disseminate that technology in part through its grant provision. But, realistically, the government is not going to pay for this. The system is going to do it because it creates such system efficiencies that it pays the system back. However, in addition to grants we encourage the system to be able to dissiminate technology by allowing consortium to develop, by allowing a hospital in a small town to work with the big employers in that town, the big insurers in that town, to get together to get a good deal on technology or on several technologies so that technologies are appropriate to the providers but are interoperable.

So this not only deals with the development of standards, with the dissemination of technology, with building the knowledge base we need to ensure the privacy of personal health information. It moves to a more modern coding system, and it will deliver to us a dramatic revolutionary increase in the quality of health care available in America. It will not only reduce medical errors and eliminate adverse drug interactions, saving millions of dollars, reduce administrative costs by billions, but also allow us to do chronic disease management for our seniors, care management for the severely ill, and upgrade the quality of diagnosis and

treatment and return ourselves to a patient-centered affordable health care system.

So this is an important bill that sets the foundation for the future. And I am astounded at my colleagues on the other side of the aisle opposing it because it does not do things we are not yet prepared to do.

Today the House of Representatives has the opportunity to pass legislation that will lay the foundation for a new era in health care. Systemwide adoption of health information technology will dramatically improve the quality of care. It will reduce medical errors, reduce duplication and unnecessary care, and bring cutting edge information to the service of doctors as they diagnose and treat their patients. It will also eliminate many of the administrative inefficiencies that characterize the American health system and strengthen and protect the security and confidentiality of health information systems. In short it will fundamentally advance the practice of medicine and improve the quality of care all Americans will have access to.

Unfortunately, the adoption of health information technology has been frustratingly slow. Since the full potential of this technology can only be harnessed if it is widely disseminated amongst all types and sizes of providers, it is imperative to pass H.R. 4157 to speed the adoption and diffusion of health information technology.

This legislation is modest in scope. It lays the groundwork for fundamental change by removing the barriers to private sector adoption. It provides for a national framework for the development and widespread dissemination of interoperable health information technology by creating an office to coordinate the development of a national health information system. It promotes common-sense cooperation between doctors and hospitals and other providers by allowing entities to provide physicians and others with hardware, software, training or IT support services. It updates diagnosis coding systems for the digital age and provides an expedited process for ongoing updating of technology standards. It begins a process for creating greater commonality amongst state and federal security and confidentiality laws and regulations in order to better protect and strengthen the exchange and health information. Additionally, it provides grants for the adoption of health information technology to coordinate care among the uninsured and to implement technology in small physician practices. Finally, it includes studies and reports on the expansion of telehealth services in Medicare.

Health information technology touches every aspect of the health care system. It will enable us to provide disease management for all those with chronic illnesses, care management for those with severe, complex illnesses, and provide access to preventive and appropriate care for the uninsured. It will reduce medical errors, adverse drug interactions, and decisive support to improve the quality of diagnosing and treating patients.

The role technology can play in the systems of health care will be as revolutionary as the role technology has played in health care research and treatments. H.R. 4157 removes barriers to greater adoption of information technology in the health system so the long overdue potential of technology can be realized in health care.

Mr. Chairman, I reserve the balance of my time.

□ 1400

Mr. STARK. Mr. Chairman, I yield myself such time as I may consume.

(Mr. STARK asked and was given permission to revise and extend his remarks.)

Mr. STARK. Mr. Chairman, I am going to start with three fairy tales, I had four, but my staff made me cut one out, fairy tales your mother would tell you.

One, if you didn't clean your ears, potatoes would grow in your ears. The second fairy tale my mother told me was if you ate too many watermelon seeds, a watermelon vine would grow out of your belly button. The third fairy tale is that this bill will do one blessed thing to help information technology.

I am not surprised that my colleagues on the other side of the aisle spin every issue in a partisan way, but it is a shame that you are now using health information technology as a pawn to advance your bankrupt ideology. The promise that information technology holds to save lives and money is vast, but H.R. 4157 forestalls that promise.

It is a lousy bill. It does nothing. H.R. 4157 doesn't provide for the development of or the adoption of interoperability standards; it does not provide funding to help providers transition to an electronic medical records system; and it does not strengthen privacy protections.

It does do one thing: It weakens Medicare's fraud and abuse laws. My colleague from Louisiana on the Ways and Means Committee acknowledged in our full committee markup that if the fraud and abuse provisions were removed from this bill, it would accomplish nothing. Zip. That is a Republican who said that.

CBO says, ''CBO estimates that enacting H.R. 4157 would not significantly affect either the rate at which the use of health technology will grow or how well that technology will be designed and implemented.''

The reason that it has no cost is it doesn't do a bloody thing.

People who I often disagree with, America's Health Insurance Plans, representing the for-profit hospitals and plans, wrote to us and said, ''The pending legislation falls short of its stated goals and will lead to serious unintended consequences for consumers. We have consistently shared these concerns, and cannot support the legislation with the following provisions as currently drafted.''

I don't know what my colleagues across the aisle think they are doing. We offered some amendments to address the serious failings of this bill and we were opposed on party line votes. Mrs. JOHNSON, Mr. SHAW and Mr. HAYWORTH voted against adding funding so that doctors could afford to transition. These same people, Mrs. JOHNSON, Mr. SHAW and Mr. HAYWORTH voted against adding provisions that contain waste, fraud and abuse. They opposed setting a date certain for the implementation of interoperability and standards. And they opposed, Mr. SHAW, Mr. HAYWORTH and Mrs. JOHNSON, an amendment to make sure that people's private medical records were protected. Unfortunately, these amendments, all rejected on party line votes, would have improved the bill somewhat.

This does not have to be a partisan issue. The Senate was able to pass unanimously a bill that is greatly better than this bad bill.

I have spent countless hours reading and discussing this issue with physicians and other experts. I spent a day at the VA to learn about their system. On numerous occasions, I have reached across the aisle in an attempt to come up with some vision about how we might move forward.

Sadly, this is just a fig leaf, a political statement for campaigns that does absolutely nothing to improve the future of information technology, which is sadly needed by our medal providers. Indeed, it does harm to that. I hope we can reject this bill, come back after the elections when there is a better climate for bipartisan work and report a bill out that will do some good.

I urge my colleagues to oppose 4157.

Mrs. JOHNSON of Connecticut. Mr. Chairman, I yield 2 minutes to the gentleman from Pennsylvania (Mr. ENGLISH).

Mr. ENGLISH of Pennsylvania. Mr. Chairman, I want to thank the gentlelady for yielding.

I rise today in support of H.R. 4157, which is not a panacea, but is an important starting point on this very important topic.

This legislation would work to ensure interoperability standards for health IT are adopted, stimulating investment in electronic health records, electronic prescribing and other forms of IT that have been demonstrated to make health care safer and more efficient.

Only through a truly interoperable, nationwide system will the benefits of health information technology be fully realized. The widespread adoption of health IT holds great promise to reduce medical errors and administrative costs, which can lead it to a dramatic improvement in the quality, the delivery and the cost of health care.

A couple of years ago in my district, I established a Health Care Cost Containment Task Force which identified preventable mistakes and physician errors as a significant source of health care costs in the system. One of my task force's recommendations was to help curb the rise of preventable medical errors through the implementation of health information technology.

I am very pleased with the work that our subcommittee and its chairman have done in this area. This is a very important initiative because, compared

to other industries, health care has a neolithic perspective when it comes to information technology.

The core idea, Mr. Chairman, behind an electronic health care system, is that doctors in one State treating an emergency room patient visiting from another State should be able to access that patient's records on a nationwide health care technology system. In this way, the patient will be better protected, the doctors will be able to treat the patient more quickly and more effectively, which would cut down on errors, and the Nation will save on health care spending.

By supporting this legislation, we make a significant move forward in bringing health care information technology fully into the 21st century and, in the process, saving lives and resources as well.

Mr. STARK. Mr. Chairman, I am pleased to yield 2 minutes to my colleague from the Virgin Islands, Dr. CHRISTENSEN, who knows firsthand how important the issue is before us today.

Mrs. CHRISTENSEN. Mr. Chairman, I thank Mr. STARK for yielding.

Mr. Chairman, there is no doubt that health information technology, or HIT, holds great promise in helping us solve some of our most pressing health care issues, such as reducing escalating health care costs and medical errors.

Yesterday I appeared before the Rules Committee to request that an amendment to H.R. 4157 be made in order which would ensure that HIT monitor and measure the racial, ethnic and geographic health disparities. The amendment, like others, was not accepted, and the committee lost an opportunity to make this bill better, to improve the health of millions of hardworking Americans who it is proven are discriminated against in health care and further reduce the health care costs caused by disparities.

Disparities that cause, for example, the maternal mortality rate for African American women to be almost five times higher than that for their white counterparts; or the infant mortality rate in African Americans and American Indian/Alaska Natives to be more than two times higher; or although they account for just one-quarter of the total U.S. population, for Latino and African Americans to account for more than two-thirds of newly reported AIDS patients.

A recent IOM report noted that anywhere from 44,000 to 98,000 deaths were caused each year by medical errors, but another report by former Surgeon General Dr. David Satcher found that health disparities caused more than 85,000 preventable deaths in African Americans every year.

The amendment I sponsored would have played a key role in helping providers, executives and administrators in the health care system better ensure an equity in the delivery of health care that does not now exist, while at the same time, further reducing unnecessary health care costs.

So today before us is a bill that doesn't have the needed privacy protections; it is underfunded, which ensures inequity will exist across the country; and does nothing to correct the greatest injustice of our time, the health care disparities that cause premature and preventable deaths and disability every day in this country that has the wherewithal to do better.

I encourage my colleagues to oppose H.R. 4157.

Mrs. JOHNSON of Connecticut. Mr. Chairman, I yield myself 40 seconds.

Mr. Chairman, my colleagues on the other side of the aisle are acting as if we had technology that, if we only had the money, we could implement. That just isn't so. Secretary Levitt and Dr. Brailer have led a phenomenal aggressive, strong effort and through their effort, working with the public and private sector, they have established standards for electronic health records and for E-prescribing.

But there are a lot more standards to be set. And in this bill, we do have a date certain, but it is way off in 2009. I think we will get there before then. But, as important, we put in this bill a very progressive, accelerated way of updating those standards, because this is going to be about continuous improvement.

My colleagues on the other side of the aisle that talk about minority health are absolutely right. Unless we get health information technology implanted and we move to chronic disease management and health care management, we cannot meet the needs of care our minority population need. That is why this bill is so important.

Mr. STARK. Mr. Chairman I am pleased at this time to yield 2 minutes to the gentleman from Rhode Island (Mr. KENNEDY), who has been a champion on the issue of information technology.

Mr. KENNEDY of Rhode Island. Mr. Chairman, I thank Mr. STARK for his leadership on this issue.

Mr. Chairman, we are talking today about the potential to revolutionize our health care system by means of technology that we are using in almost every other industry currently in our society except the industry that probably could benefit the most from it, and that is our health care system.

We are after this for many different reasons, but one of the reasons I am after it for is because I want to reduce the cost of health care for my constituents. My constituents, whether they be businesses that are paying exorbitant premiums for their workers, or the workers who are paying high premiums themselves, or whether it is not only the consumer, but it is even the providers that are getting shortchanged on their reimbursement, no one is happy with the current health care system.

So, Mr. Chairman, what we could do today is do what has been already outlined by the Rand report, which says we could save $162 billion in direct costs because we would now not have to duplicate care if we have care now that is tracked, so we don't have to go to four different doctors and not have each doctor repeat the same test.

We can now make sure that the best in care gets to everybody, because now the evidence base will be available to all doctors, no matter where they live in this country, so people will get the same and the best of care.

But, frankly, Mr. Chairman, this bill doesn't do it. This bill doesn't do it. Why? Because it doesn't implement the quality standards to ensure that people get that good care. It doesn't ensure that we move quickly to the adoption, because, one, it sets up the adoption date too far in the future. Why are we waiting? If we are acknowledging this is important, why are we putting this off?

Next, when it comes to making sure that there is privacy, I don't frankly understand how we can go into an electronic age in medical records and not ensure that people's personal medical privacy is protected.

For those reasons, I will be voting against this legislation.

Mrs. JOHNSON of Connecticut. Mr. Chairman, yield 2 minutes to the gentleman from Missouri (Mr. HULSHOF).

(Mr. HULSHOF asked and was given permission to revise and extend his remarks.)

Mr. HULSHOF. Mr. Chairman, I would like to thank the Chair of the Health Subcommittee, especially for her bold initiative and leadership on this bill, for really trying to wrestle with a very important issue and looking ahead and being a visionary as far as employing technology and how we can improve health care in this country. It is a good bill. I am proud to be an original cosponsor.

I would especially like to touch some the telemedicine, telehealth, provisions. I appreciate very much that Mr. THOMPSON of California and I have put together a bill where the bottom line, Mr. Chairman, is that with advancements in telecommunications, health care providers in small communities can now access resources that are available in the finest hospitals and academic institutions in the country.

The quality of one's health care should not be dictated by one's ZIP Code. So I am very excited about the fact that technologies like interactive video conferencing, the Internet, satellite, are already systematically changing the face of our Nation's health care.

This legislation directs the Secretary to work with the telehealth community, especially as far as services across State lines. We know that that is an issue. We want to expand the origination and consulting sites so that more of our underserved communities will have access to the best health care that the community has to offer.

□ 1415

I would like to brag a little bit, Mr. Chairman, because telehealth patients

from small towns throughout my district in Missouri have been receiving specialist care or services from a variety of specialists, including mental health providers. I know that is certainly a hot-button issue for many here, without having to take available time, maybe, away for caring for a loved one or from work or for school or for other parental duties.

Right now there are 2,000 patients in Missouri that are cared for using Missouri's telehealth network. It is estimated over 40,000 radiological examinations have been performed. In fact, one example: a critical-access hospital in the small town of Macon, Missouri, unexpectedly lost the only radiologist in the area. There was not another specialist within that underserved area.

Fortunately, the University of Missouri stepped in to provide coverage during this 4-month period of time so this small community could have access to a qualified radiologist. Again, there are lots of good things in this bill. But telemedicine is one piece of it. I commend the chairwoman and I urge everyone to support it.

I thank the chair of the Health Subcommittee, on which I serve, for her bold leadership on this bill and improving health information technology in this country.

H.R. 4157 will launch the American healthcare system into full capacity to take advantage of the best technology. This will give all Americans better health care, more accessible medical records, and better quality of care.

It is a good bill of which I am proud to be an original cosponsor.

I would like to touch on the telemedicine provisions of the bill.

The Health Information Technology Promotion Act includes important provisions for the advancement of telehealth services—Requires the Secretary of HHS to take steps that expedite the provision of telehealth services across State lines by taking a closer look at State licensure issues; requires the Secretary to conduct two studies: (1) a study on the use of store and forward technology in the provision of telehealth services; and (2) a study on the coverage of telehealth services provided in home health agencies, county mental health clinics and other publicly funded mental health facilities.

Advancement in telecommunications now allows health care providers in small communities to access the resources available in the finest hospitals and academic institutions. Individuals in this country should receive the health care they need regardless of where they live. A person's address should not dictate the state of their health. Technologies such as interactive videoconferencing, the Internet and satellite are already systematically changing the face of our Nation's health care.

In 2000, the Congressional Budget Office estimated that the telehealth provisions of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, BIPA, would cost $150 million over 5 years. In June I asked CMS to provide me with information on how much the Federal Government has spent to date to get an idea of how close we are to CBO projections. I was astonished to find that since October 1, 2001 Medicare has only reimbursed for approximately $1.2 million total for telehealth services and originating site facility fees. This illustrates that the Federal Government has made a minor contribution compared to what we were expected to spend. And more needs to be done.

This legislation highlights the capabilities of telemedicine by directing the Secretary to work with the telehealth community to find solutions to the services across State lines issue, and expanding origination and consulting sites so more of our underserved communities will have access to the best health care this country has to offer.

I would also like to brag on how, because of telehealth, patients from small towns throughout my district are able to receive services from a variety of specialists, including mental health providers, without having to take valuable time away from work, school or parental duties.

Currently in Missouri, over 2,000 patients per year are cared for using the Missouri Telehealth Network and it is estimated that over 40,000 radiology exams have been performed. In fact, in my district, a Critical Access Hospital in the town of Macon unexpectedly lost its only radiologist, leaving the area without a specialist in this area. Fortunately, the University of Missouri stepped in to provide coverage through the telehealth network for a 4-month period until a new radiologist was hired. Without this option, Macon residents would have been forced to either commute or simply go without radiological care.

It is my hope that via this legislation, rural and underserved areas in my district and across the country will be able to find the same successes experienced with the Missouri Telehealth Network.

Mr. STARK. Mr. Chairman, I yield 2½ minutes to the gentleman from Texas (Mr. DOGGETT).

Mr. DOGGETT. Mr. Chairman, during the 12 years that Republicans have controlled this House, they have done very little to address the real concerns of families confronted with a health care crisis. This afternoon during rush hour, some family, in fact probably many families, will suffer a severe auto accident on the way home.

Perhaps a mom will be found to have breast cancer, or a child a serious childhood disease. And as these health care challenges emerge, tens of thousands of families across America will end up not only driven into despair but into bankruptcy.

And yet Republicans have not offered real solutions to address those kinds of problems. Recognizing their failures earlier this year, both Senate and House Republican leaders declared there would be a ''health care week.'' Well, the Senate took up their ''health care week,'' and every old, retread Republican proposal that they had was rejected.

So I guess too embarrassed to have ''health care week'' here in the House, even though they declared it, the Republicans canceled ''health care week,'' just like they have canceled so many of the commitments that they made back in 1994 to the American people.

And what they have left as their one new idea for the crisis that American families face in health care is this pitiful proposal. They have discovered that the answer to the problems American families face with health care is not what the American families thought was their problem about getting access to affordable, quality health care. No, it is bad handwriting. Yes. We all know the legendary bad handwriting of physicians that is the subject of cartoons and stories.

But by golly, they are solving that. All of these physicians, and the hospitals and the clinics, will be using electronic records and solve that penmanship problem. Well, that is not a bad idea. It is just that they do not put their money where their mouth is.

They tell the physicians and the clinics, you figure out how to pay for this technology. And in the process of this transformation, once again, as they have done with our library records and our phone records and our veterans records, they couldn't really care less about privacy.

Think about whether you want your psychiatric records, your prescription records on the Internet for other people to see. Because this legislation does not provide the guarantee of privacy. And so fearful are they of a true debate about protecting the privacy rights of Americans to their medical records, to their health care records, that may affect their future employment, that may affect their future family relations, that may affect their ability to get insurance.

So fearful are they of a debate about that, they refuse to let us offer even one amendment to address patient privacy.

Mrs. JOHNSON of Connecticut. Mr. Chairman, I ask how much time is remaining.

The CHAIRMAN. The gentlewoman has 2½ minutes remaining.

Mrs. JOHNSON of Connecticut. Mr. Chairman, I yield 1 minute to the gentleman from New Jersey (Mr. FERGUSON).

Mr. FERGUSON. Mr. Chairman, I thank the gentlewoman for yielding me time.

Mr. Chairman, I rise today in favor of a bill that would help us usher in 21st-century medicine into the doctors' offices of our country. By encouraging the dissemination of health information technology, we move full speed ahead toward establishing an infrastructure necessary to create an environment where errors are reduced and care is improved.

This bill promotes cooperation between doctors and hospitals and provides physicians with the IT support services they need to establish this infrastructure. In particular, I am pleased this bill includes an amendment that I sponsored in the Energy and Commerce Committee with Congressman TOWNS that would provide grants for the use of health information technology to coordinate care for the uninsured.

These grants are targeted to integrated health systems that have demonstrated success in the past for treating the uninsured and underinsured populations in underserved communities. This is just one example of how this bill helps to provide the necessary framework for health IT for all Americans.

Mr. Chairman, I invite all of our colleagues to support this commonsense legislation. It will help establish a framework of care for all Americans as we head into the 21st century.

Mr. STARK. Mr. Chairman, to close debate for our side, I yield 1 minute to the gentleman from Maryland (Mr. HOYER), the distinguished minority whip, who supports information technology, but realizes this bill does nothing to help it.

Mr. HOYER. Mr. Chairman, Democrats worked with the health care and technology industries to write a bill that would lead to the widespread use of information technology in medicine, a necessity. The effective use of it can reduce medical errors, health care costs, and save lives.

Mr. Chairman, we should be taking up the Dingell-Rangel bill today, a bill that was virtually identical to the bill that passed unanimously in the United States Senate. Instead, we are voting on a Republican bill that fails to provide for the development or adoption of interoperability standards, that fails to provide funding to help providers transition to an electronic medical records system, and that fails to strengthen privacy protections.

What a shame. What a missed opportunity. We should oppose this bill, and we should bring the Rangel bill to the floor.

Mrs. JOHNSON of Connecticut. Mr. Chairman, I yield 30 seconds to the gentleman from Pennsylvania (Mr. MURPHY).

Mr. MURPHY. Mr. Chairman, for the record I would like to note that the HIPAA laws do apply to this with regard to privacy, whereby there would be fines up to $250,000 and up to 10 years in prison for disclosure or obtaining health information in many of these areas. So it does apply.

The second is the CBO report which is being taken out of context. It mentioned that there can be savings for Medicare in this. And as hospitals learn to adapt to health information technology, if they do not adapt right, that may be more costly; but overall there are many savings in this.

Mrs. JOHNSON of Connecticut. Mr. Chairman, I yield the balance of our time to the gentleman from Illinois (Mr. KIRK).

Mr. KIRK. Mr. Chairman, I rise in support of this legislation because it will dramatically improve civilian health care, the way this technology has already done for veterans across America. When Katrina hit New Orleans, many civilian hospital record rooms were wiped out, including the medical history of thousands.

Meanwhile, American veterans already had fully electronic medical records, and their medical histories were seamlessly transmitted to other VA hospitals in Baton Rouge or Houston for complete care.

There is a reason why Senator CLINTON and Speaker Gingrich both so strongly support a full deployment of electronic medical records. They reduce medical errors and improve care as they already have demonstrated to do so heavily in the VA.

Our Federal law already sanctions any violation of medical privacy with up to 10 years in jail and $250,000 fines.

This legislation is the third part of our suburban agenda, commonsense reforms to improve the health care for all American patients.

Mr. CLAY. Mr. Chairman, I rise today in support of H.R. 4157, the Health Information Technology Promotion Act of 2006. I believe the bill before us is a thoughtful and measured approach for establishing the Federal government's role in promoting the adoption of a national health information network.

The bill before us takes the logical step of codifying the Office of the National Coordinator for Health IT at HHS. This will ensure long-term stability and continuity in the establishment of policies and programs relating to network interoperability, product certification, and adoption throughout the health care stakeholder community. It will also prove beneficial to both providers and public health agencies nationwide, as vital clinical, prescribing, and laboratory information will be accessible through one integrated network.

Just last week, the Institute of Medicine released its report on the number error rates involved with prescribing patient medications, and how the use of e-prescribing would contribute to reducing the number of annual errors in hospitals by 400,000 and save an estimated $3.5 billion this year alone. Utilizing health IT is not only economically beneficial, but will also prevent many costly and unnecessary patient injuries relating to drug interactions.

I realize the bill before us is not a perfect one, and I agree with my friends who have stated that stronger protections for the security and privacy of personal health information are desperately needed. Let me be clear that I'm very disappointed that some thoughtful amendments offered by my Democratic colleagues on security and privacy will not be considered today. I do not believe, however, that health IT platforms used for the preservation or transmission of identifiable patient information are any more vulnerable to security breaches than modern paper-based record systems.

In fact, many providers, insurers, and hospitals have already transitioned from paper based records to electronic health record systems, while taking internal steps to ensure that appropriate security and access controls are built into their IT systems and are compliant with current law. All we are doing today is taking the next step to ensure that all who choose to utilize health IT have a blueprint for system standards to ensure optimal functionality for all participants.

I thank Congresswoman JOHNSON and Congressman DEAL for their good work.

Mr. CARDIN. Mr. Chairman, I rise in opposition to this bill. I am disappointed that the House has missed an opportunity to promote in a meaningful way our health care system's transition from a paper-based medical records system to an electronic one. Congress is in nearly unanimous agreement that this move is necessary, and that it is in the best interest of patients, providers, and health care quality over all.

But it appears that we have before us legislation that will do little to move the Nation toward that goal, and that in some respects, may be harmful. As a member of the Ways and Means Committee, which considered this bill earlier this year, I had the opportunity to vote on several amendments that would have strengthened this bill, that would have enabled our Committee to bring this bill to the floor with bipartisan support. Those amendments would have added funding so that doctors could afford to transition to electronic medical records; removed provisions that expand fraud and abuse, set a date certain for the implementation of interoperability standards, and guaranteed the confidentiality of personal health information. Unfortunately, each was defeated on a party-line vote.

So the bill before us today still contains several fundamental problems. The first is the lack of strong privacy protections. Mr. Chairman, I wonder how many breaches of supposedly secure electronic medical records must occur before we get serious about enacting strong privacy protections into law. In two weeks, we will mark the 10th anniversary of the Health Insurance Portability and Accountability Act. Privacy regulations stemming from that law were finally issued in 2001. Ten years ago, Americans' familiarity with electronic communication and electronic transfer of information was quite limited. HIPAA does not protect individuals.

The second is a lack of funding. My colleagues, Mr. WYNN, Mr. ENGEL, and Ms. SCHAKOWSKY and I offered an amendment that would have provided grants for community health centers and hospitals with high numbers of low-income patients. These are the facilities that already face severe financial strains. They include many community health centers in Baltimore and larger facilities such as Prince George's Hospital Center in my home state of Maryland. They do not have extra money to implement expensive health information technology systems. Our amendment would have given them needed help to take advantage of health information technology for their patients, many of whom face significant health challenges due to chronic illnesses. If adopted, our amendment would have helped these facilities leap the financial hurdles that will otherwise prevent the spread of health information technology. Unfortunately, the Rules Committee refused to allow our amendment to be made in order.

Mr. Chairman, many of my colleagues have made this point, but it bears repeating: The nonpartisan Congressional Budget Office estimates that enacting this bill in its present form ''would not significantly affect either the rate at which the use of health technology will grow or how well that technology will be designed and implemented.'' The lack of funding is one of the primary reasons why.

I am also very concerned about the exceptions to the Stark anti-self-referral and anti-kickback laws contained in the underlying bill. These provisions would serve to seriously weaken these important consumer protection

laws. In H.R. 4157 as it is being considered today, physicians could be offered free or discounted technology in exchange for referring their patients to a facility or for a particular service. According to the Congressional Budget Office, these exceptions would raise health care costs.

Mr. Chairman, I will vote for the motion to recommit, which will protect medical privacy. It will ensure that patients can keep their medical records out of electronic databases unless they first give their permission. It will require patient notification if their health information is misused, lost, or stolen. It requires the use of encryption and other safeguards against theft. Importantly, it would permit patients to limit access to particularly sensitive information, such as mental health data. Finally it would protect state privacy laws that may be more protective of patient confidentiality.

I support the provisions of the bipartisan bill passed by the Senate, and I would hope that, for the sake of improved patient care, for better access to health information technology, for better privacy standards, that is the bill that emerges from conference. I urge my colleagues to join me in opposition to H.R. 4157.

Mr. VAN HOLLEN. Mr. Chairman, I rise today in reluctant opposition to H.R. 4157, the Information Technology Promotion Act of 2005. It is unfortunate that the House Republican leadership refused to allow this Congress the opportunity to strengthen this bill and protect the privacy of patients.

Like many of my colleagues, I support moving our health care system into the ''information age''—it holds the promise of saving lives, saving money, and saving time. However, I am concerned that H.R. 4157 does not adequately protect the privacy of patients. In light of millions of electronic data records being exposed due to recent high-profile security breaches, it is troubling that this legislation does not adequately address this critical issue.

Unfortunately, the House Republican leadership would not allow us the opportunity to vote on an alternative bill that was based on the bipartisan Senate health information technology legislation (S. 1418)—which unanimously passed that chamber. This alternative proposal included safeguards for Americans to protect their personal medical records from identity thieves.

Mr. Chairman, health information technology should not be a partisan issue. Congress should not miss the opportunity to transition our health care into the 21st century, but it must be done in a manner that will protect the sensitive health information of millions of Americans. I am hopeful that the final version of the legislation will be fashioned in a bipartisan, bicameral fashion by the House-Senate Conference.

Mr. KIND. Mr. Chairman, I rise in appreciation that House Leadership has at last brought a health information technology bill to the Floor. As a cochair of the New Democrat Coalition, I have been a long-time supporter of health IT. I believe health IT, if done correctly, will highlight the need for personal accountability in health care, advance technological innovation, promote fiscal responsibility and, most importantly, improve health and save lives. Additionally, great strides can be made in homeland security as well as tracking disease and infection.

I am pleased that H.R. 4157 will codify in law the Office of the National Coordinator for Health Information Technology and that the coordinator will be tasked with devising a national strategic plan for implementing health IT. Additionally, the grant money authorized by the bill is a worthwhile, if small, step in the right direction. Representing western Wisconsin, I know too well how difficult it is for small medical practices to afford the purchase and upkeep of software and hardware needed for electronic medical records. The $5 million in grants to rural or underserved urban areas is the first of many such grants Congress must facilitate.

While I am pleased the bill is moving forward, I am disappointed that negotiations were not done in a more bipartisan manner. It is good to see that harmful and invasive policies on privacy issues were removed from the bill, and I am hopeful that when the House and Senate meet in conference, members will take a hard look at strengthening further the bill's privacy provisions.

Mr. Chairman, I plan on voting for this health IT bill and look forward to working with the Senate on improving it. America's doctors, nurses, and patients deserve 21st century technology in the health care system, and it is past time for Congress to be acting on this issue.

The CHAIRMAN. All time for general debate has expired.

In lieu of the amendments recommended by the Committees on Energy and Commerce and Ways and Means printed in the bill, the amendment in the nature of a substitute printed in part A of House Report 109–603, modified by the amendment printed in part B of the report, is adopted. The bill, as amended, shall be considered as the original bill for purpose of further amendment under the 5-minute rule and shall be considered as read.

The text of the bill, as amended, is as follows:

SECTION 1. SHORT TITLE AND TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Health Information Technology Promotion Act of 2006''.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

SEC. 2. PRESERVING PRIVACY AND SECURITY LAWS.

Nothing in this Act (or the amendments made by this Act) shall be construed to affect the scope, substance, or applicability of section 264(c) of the Health Insurance Portability and Accountability Act of 1996 and any regulation issued pursuant to such section.

TITLE I—COORDINATION FOR, PLANNING FOR, AND INTEROPERABILITY OF HEALTH INFORMATION TECHNOLOGY

SEC. 101. OFFICE OF THE NATIONAL COORDINATOR FOR HEALTH INFORMATION TECHNOLOGY.

(a) IN GENERAL.—Title II of the Public Health Service Act is amended by adding at the end the following new part:

''PART D—HEALTH INFORMATION TECHNOLOGY

''SEC. 271. OFFICE OF THE NATIONAL COORDINATOR FOR HEALTH INFORMATION TECHNOLOGY.

''(a) ESTABLISHMENT.—There is established within the Department of Health and Human Services an Office of the National Coordinator for Health Information Technology that shall be headed by the National Coordinator for Health Information Technology (referred to in this part as the 'National Coordinator'). The National Coordinator shall be appointed by and report directly to the Secretary. The National Coordinator shall be paid at a rate equal to the rate of basic pay for level IV of the Executive Schedule.

''(b) GOALS OF NATIONWIDE INTEROPERABLE HEALTH INFORMATION TECHNOLOGY INFRASTRUCTURE.—The National Coordinator shall

perform the duties under subsection (c) in a manner consistent with the development of a nationwide interoperable health information technology infrastructure that—

''(1) improves health care quality, promotes data accuracy, reduces medical errors, increases the efficiency of care, and advances the delivery of appropriate, evidence-based health care services;

''(2) promotes wellness, disease prevention, and management of chronic illnesses by increasing the availability and transparency of information related to the health care needs of an individual for such individual;

''(3) promotes the availability of appropriate and accurate information necessary to make medical decisions in a usable form at the time and in the location that the medical service involved is provided;

''(4) produces greater value for health care expenditures by reducing health care costs that result from inefficiency, medical errors, inappropriate care, and incomplete or inaccurate information;

''(5) promotes a more effective marketplace, greater competition, greater systems analysis, increased consumer choice, enhanced quality, and improved outcomes in health care services;

''(6) with respect to health information of consumers, advances the portability of such information and the ability of such consumers to share and use such information to assist in the management of their health care;

''(7) improves the coordination of information and the provision of such services through an effective infrastructure for the secure and authorized exchange and use of health care information;

''(8) is consistent with legally applicable requirements with respect to securing and protecting the confidentiality of individually identifiable health information of a patient;

''(9) promotes the creation and maintenance of transportable, secure, Internet-based personal health records, including promoting the efforts of health care payers and health plan administrators for a health plan, such as Federal agencies, private health plans, and third party administrators, to provide for such records on behalf of members of such a plan;

''(10) promotes access to and review of the electronic health record of a patient by such patient;

''(11) promotes health research and health care quality research and assessment; and

''(12) promotes the efficient and streamlined development, submission, and maintenance of electronic health care clinical trial data.

''(c) DUTIES OF THE NATIONAL COORDINATOR.—

''(1) STRATEGIC PLANNER FOR INTEROPERABLE HEALTH INFORMATION TECHNOLOGY.—The National Coordinator shall provide for a strategic plan for the nationwide implementation of interoperable health information technology in both the public and private health care sectors consistent with subsection (b).

''(2) PRINCIPAL ADVISOR TO THE SECRETARY.—The National Coordinator shall serve as the principal advisor to the Secretary on the development, application, and use of health information technology, and shall coordinate the policies and programs of the Department of Health and Human Services for promoting the use of health information technology.

''(3) INTRAGOVERNMENTAL COORDINATOR.—The National Coordinator shall ensure that health information technology policies and programs of the Department of Health and Human Services are coordinated with those of relevant executive branch agencies and departments with a goal to avoid duplication of effort, to align the health information architecture of each agency or department toward a common approach, to ensure that each agency or department conducts programs within the areas of its greatest expertise and its mission in order to create a national interoperable health information system capable of meeting national public health needs effectively and efficiently, and to assist Federal agencies and departments in security programs, policies, and protections to prevent unauthorized access to individually identifiable health information created, maintained, or in the temporary possession of that agency or department. The coordination authority provided to the National Coordinator under the previous sentence shall supercede any such authority otherwise provided to any other official of the Department of Health and Human Services. For the purposes of this paragraph, the term 'unauthorized access' means access that is not authorized by that agency or department including unauthorized employee access.

''(4) ADVISOR TO OMB.—The National Coordinator shall provide to the Director of the Office of Management and Budget comments and advice with respect to specific Federal health information technology programs.

''(5) PROMOTER OF HEALTH INFORMATION TECHNOLOGY IN MEDICALLY UNDERSERVED COMMUNITIES.—The National Coordinator shall—

''(A) identify sources of funds that will be made available to promote and support the planning and adoption of health information technology in medically underserved communities, including in urban and rural areas, either through grants or technical assistance;

''(B) coordinate with the funding sources to help such communities connect to identified funding; and

''(C) collaborate with the Agency for Healthcare Research and Quality and the Health Services Resources Administration and other Federal agencies to support technical assistance, knowledge dissemination, and resource development, to medically underserved communities seeking to plan for and adopt technology and establish electronic health information networks across providers.''.

(b) TREATMENT OF EXECUTIVE ORDER 13335.—Executive Order 13335 shall not have any force or effect after the date of the enactment of this Act.

(c) TRANSITION FROM ONCHIT UNDER EXECUTIVE ORDER.—

(1) IN GENERAL.—All functions, personnel, assets, liabilities, administrative actions, and statutory reporting requirements applicable to the old National Coordinator or the Office of the old National Coordinator on the date before the date of the enactment of this Act shall be transferred, and applied in the same manner and under the same terms and conditions, to the new National Coordinator and the Office of the new National Coordinator as of the date of the enactment of this Act.

(2) RULE OF CONSTRUCTION.— Nothing in this section or the amendment made by this section shall be construed as requiring the duplication of Federal efforts with respect to the establishment of the Office of the National Coordinator for Health Information Technology, regardless of whether such efforts are carried out before or after the date of the enactment of this Act.

(3) ACTING NATIONAL COORDINATOR.—Before the appointment of the new National Coordinator, the old National Coordinator shall act as the National Coordinator for Health Information Technology until the office is filled as provided in section 271(a) of the Public Health Service Act, as added by subsection (a). The Secretary of Health and Human Services may appoint the old National Coordinator as the new National Coordinator.

(4) DEFINITIONS.—For purposes of this subsection:

(A) NEW NATIONAL COORDINATOR.—The term ''new National Coordinator'' means the National Coordinator for Health Information Technology appointed under section 271(a) of the Public Health Service Act, as added by subsection (a).

(B) OLD NATIONAL COORDINATOR.—The term ''old National Coordinator'' means the National Coordinator for Health Information Technology appointed under Executive Order 13335.

SEC. 102. REPORT ON THE AMERICAN HEALTH INFORMATION COMMUNITY.

Not later than one year after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to Congress a report on the work conducted by the American Health Information Community (in this section referred to as ''AHIC''), as established by the Secretary. Such report shall include the following:

(1) A description of the accomplishments of AHIC, with respect to the promotion of the development of national guidelines, the development of a nationwide health information network, and the increased adoption of health information technology.

(2) Information on how model privacy and security policies may be used to protect confidentiality of health information, and an assessment of how existing policies compare to such model policies.

(3) Information on the progress in—

(A) establishing uniform industry-wide health information technology standards;

(B) achieving an internet-based nationwide health information network;

(C) achieving interoperable electronic health record adoption across health care providers; and

(D) creating technological innovations to promote security and confidentiality of individually identifiable health information.

(4) Recommendations for the transition of AHIC to a longer-term or permanent advisory and facilitation entity, including—

(A) a schedule for such transition;

(B) options for structuring the entity as either a public-private or private sector entity;

(C) the collaborative role of the Federal Government in the entity;

(D) steps for—

(i) continued leadership in the facilitation of guidelines or standards;

(ii) the alignment of financial incentives; and

(iii) the long-term plan for health care transformation through information technology; and

(E) the elimination or revision of the functions of AHIC during the development of the nationwide health information network.

SEC. 103. INTEROPERABILITY PLANNING PROCESS; FEDERAL INFORMATION COLLECTION ACTIVITIES.

Part D of title II of the Public Health Service Act, as added by section 101(a), is amended by adding at the end the following new section:

''SEC. 272. INTEROPERABILITY PLANNING PROCESS; FEDERAL INFORMATION COLLECTION ACTIVITIES.

''(a) STRATEGIC INTEROPERABILITY PLANNING PROCESS.—

''(1) ASSESSMENT AND ENDORSEMENT OF CORE STRATEGIC GUIDELINES.—

''(A) IN GENERAL.—Not later than December 31, 2006, the National Coordinator shall publish a strategic plan, including a schedule, for the assessment and the endorsement

of core interoperability guidelines for significant use cases consistent with this subsection. The National Coordinator may update such plan from time to time.

''(B) ENDORSEMENT.—

''(i) IN GENERAL.—Consistent with the schedule under this paragraph and not later than one year after the publication of such schedule, the National Coordinator shall endorse a subset of core interoperability guidelines for significant use cases. The National Coordinator shall continue to endorse subsets of core interoperability guidelines for significant use cases annually consistent with the schedule published pursuant to this paragraph, with endorsement of all such guidelines completed not later than August 31, 2009.

''(ii) CONSULTATION.—All such endorsements shall be in consultation with the American Health Information Community and other appropriate entities.

''(iii) VOLUNTARY COMPLIANCE.—Compliance with such guidelines shall be voluntary, subject to subsection (b)(1).

''(C) CONSULTATION WITH OTHER PARTIES.—The National Coordinator shall develop and implement such strategic plan in consultation with the American Health Information Community and other appropriate entities.

''(D) DEFINITIONS.—For purposes of this section:

''(i) INTEROPERABILITY GUIDELINE.—The term 'interoperability guideline' means a guideline to improve and promote the interoperability of health information technology for purposes of electronically accessing and exchanging health information. Such term includes named standards, architectures, software schemes for identification, authentication, and security, and other information needed to ensure the reproducible development of common solutions across disparate entities.

''(ii) CORE INTEROPERABILITY GUIDELINE.—The term 'core interoperability guideline' means an interoperability guideline that the National Coordinator determines is essential and necessary for purposes described in clause (i).

''(iii) SIGNIFICANT USE CASE.—The term 'significant use case' means a category (as specified by the National Coordinator) that identifies a significant use or purpose for the interoperability of health information technology, such as for the exchange of laboratory information, drug prescribing, clinical research, and electronic health records.

''(2) NATIONAL SURVEY.—

''(A) IN GENERAL.—Not later than August 31, 2008, the National Coordinator shall conduct one or more surveys designed to measure the capability of entities (including Federal agencies, State and local government agencies, and private sector entities) to exchange electronic health information by appropriate significant use case. Such surveys shall identify the extent to which the type of health information, the use for such information, or any other appropriate characterization of such information may relate to the capability of such entities to exchange health information in a manner that is consistent with methods to improve the interoperability of health information and with core interoperability guidelines.

''(B) DISSEMINATION OF SURVEY RESULTS.—The National Coordinator shall disseminate the results of such surveys in a manner so as to—

''(i) inform the public on the capabilities of entities to exchange electronic health information;

''(ii) assist in establishing a more interoperable information architecture; and

''(iii) identify the status of health information systems used in Federal agencies and the status of such systems with respect to interoperability guidelines.

''(b) FEDERAL HEALTH INFORMATION COLLECTION ACTIVITIES.—

''(1) REQUIREMENTS.—With respect to a core interoperability guideline endorsed under subsection (a)(1)(B) for a significant use case, the President shall take measures to ensure that Federal activities involving the broad collection and submission of health information are consistent with such guideline within three years after the date of such endorsement.

''(2) PROMOTING USE OF NON-IDENTIFIABLE HEALTH INFORMATION TO IMPROVE HEALTH RESEARCH AND HEALTH CARE QUALITY.—

''(A) IN GENERAL.—Where feasible, and consistent with applicable privacy or security or other laws, the President, in consultation with the Secretary, shall take measures to allow timely access to useful categories of non-identifiable health information in records maintained by the Federal government, or maintained by entities under contract with the Federal government, to advance health care quality and health research where such information is in a form that can be used in such research. The President shall consult with appropriate Federal agencies, and solicit public comment, on useful categories of information, and appropriate measures to take. The President may consider the administrative burden and the potential for improvements in health care quality in determining such appropriate measures. In addition, the President, in consultation with the Secretary, shall encourage voluntary private and public sector efforts to allow access to such useful categories of non-identifiable health information to advance health care quality and health research.

''(B) NON-IDENTIFIABLE HEALTH INFORMATION DEFINED.—For purposes of this paragraph, the term 'non-identifiable health information' means information that is not individually identifiable health information as defined in rules promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d-2 note), and includes information that has been de-identified so that it is no longer individually identifiable health information, as defined in such rules.

''(3) ANNUAL REVIEW AND REPORT.—For each year during the five-year period following the date of the enactment of this section, the National Coordinator shall review the operation of health information collection by and submission to the Federal government and the purchases (and planned purchases) of health information technology by the Federal government. For each such year and based on the review for such year, the National Coordinator shall submit to the President and Congress recommendations on methods to—

''(A) streamline (and eliminate redundancy in) Federal systems used for the collection and submission of health information;

''(B) improve efficiency in such collection and submission;

''(C) increase the ability to assess health care quality; and

''(D) reduce health care costs.''.

SEC. 104. GRANTS TO INTEGRATED HEALTH SYSTEMS TO PROMOTE HEALTH INFORMATION TECHNOLOGIES TO IMPROVE COORDINATION OF CARE FOR THE UNINSURED, UNDERINSURED, AND MEDICALLY UNDERSERVED.

Subpart I of part D of title III of the Public Health Service Act (42 U.S.C. 254b et seq.) is amended by adding at the end the following:

''SEC. 330M. GRANTS FOR IMPROVEMENT OF THE COORDINATION OF CARE FOR THE UNINSURED, UNDERINSURED, AND MEDICALLY UNDERSERVED.

''(a) IN GENERAL.—The Secretary may make grants to integrated health care systems, in accordance with this section, for projects to better coordinate the provision of health care through the adoption of new health information technology, or the significant improvement of existing health information technology, to improve the provision of health care to uninsured, underinsured, and medically underserved individuals (including in urban and rural areas) through health-related information about such individuals, throughout such a system and at the point of service.

''(b) ELIGIBILITY.—

''(1) APPLICATION.—To be eligible to receive a grant under this section, an integrated health care system shall prepare and submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require, including—

''(A) a description of the project that the system will carry out using the funds provided under the grant;

''(B) a description of the manner in which the project funded under the grant will advance the goal specified in subsection (a); and

''(C) a description of the populations to be served by the adoption or improvement of health information technology.

''(2) OPTIONAL REPORTING CONDITION.—The Secretary may also condition the provision of a grant to an integrated health care system under this section for a project on the submission by such system to the Secretary of a report on the impact of the health information technology adopted (or improved) under such project on the delivery of health care and the quality of care (in accordance with applicable measures of such quality). Such report shall be at such time and in such form and manner as specified by the Secretary.

''(c) INTEGRATED HEALTH CARE SYSTEM DEFINED.—For purposes of this section, the term 'integrated health care system' means a system of health care providers that is organized to provide care in a coordinated fashion and has a demonstrated commitment to provide uninsured, underinsured, and medically underserved individuals with access to such care.

''(d) PRIORITIES.—In making grants under this section, the Secretary shall give priority to an integrated health care system—

''(1) that can demonstrate past successful community-wide efforts to improve the quality of care provided and the coordination of care for the uninsured, underinsured, and medically underserved; or

''(2) if the project to be funded through such a grant—

''(A) will improve the delivery of health care and the quality of care provided; and

''(B) will demonstrate savings for State or Federal health care benefits programs or entities legally obligated under Federal law to provide health care from the reduction of duplicative health care services, administrative costs, and medical errors.

''(e) LIMITATION, MATCHING REQUIREMENT, AND CONDITIONS.—

''(1) LIMITATION ON USE OF FUNDS.—None of the funds provided under a grant made under this section may be used for a project providing for the adoption or improvement of health information technology that is used exclusively for financial record keeping, billing, or other non-clinical applications.

''(2) MATCHING REQUIREMENT.—To be eligible for a grant under this section an integrated health care system shall contribute

non-Federal contributions to the costs of carrying out the project for which the grant is awarded in an amount equal to $1 for each $5 of Federal funds provided under the grant.

''(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $15,000,000 for each of fiscal years 2007 and 2008.''.

SEC. 105. SMALL PHYSICIAN PRACTICE DEMONSTRATION GRANTS.

Part D of title II of the Public Health Service Act, as added by section 101(a) and amended by section 103, is amended by adding at the end the following new section:

''SEC. 273. SMALL PHYSICIAN PRACTICE DEMONSTRATION GRANTS.

''(a) IN GENERAL.—The Secretary shall establish a demonstration program under which the Secretary makes grants to small physician practices (including such practices that furnish services to individuals with chronic illnesses) that are located in rural areas or medically underserved urban areas for the purchase and support of health information technology.

''(b) ELIGIBILITY.—To be eligible to receive a grant under this section, an applicant shall prepare and submit to the Secretary an application, at such time, in such manner, and containing such information, as the Secretary may require.

''(c) REPORTING.—

''(1) REQUIRED REPORTS BY SMALL PHYSICIAN PRACTICES.—A small physician practice receiving a grant under subsection (a) shall submit to the Secretary an evaluation on the health information technology funded by such grant. Such evaluation shall include information on—

''(A) barriers to the adoption of health information technology by the small physician practice;

''(B) issues for such practice in the use of health information technology;

''(C) the effect health information technology will have on the quality of health care furnished by such practice; and

''(D) the effect of any medical liability rules on such practice.

''(2) REPORT TO CONGRESS.—Not later than January 1, 2009, the Secretary shall submit to Congress a report on the results of the demonstration program under this section.

''(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $5,000,000 for each of fiscal years 2007 and 2008.''.

TITLE II—TRANSACTION STANDARDS, CODES, AND INFORMATION

SEC. 201. PROCEDURES TO ENSURE TIMELY UPDATING OF STANDARDS THAT ENABLE ELECTRONIC EXCHANGES.

Section 1174(b) of the Social Security Act (42 U.S.C. 1320d–3(b)) is amended—

(1) in paragraph (1)—

(A) in the first sentence, by inserting ''and in accordance with paragraph (3)'' before the period; and

(B) by adding at the end the following new sentence: ''For purposes of this subsection and section 1173(c)(2), the term 'modification' includes a new version or a version upgrade.''; and

(2) by adding at the end the following new paragraph:

''(3) EXPEDITED PROCEDURES FOR ADOPTION OF ADDITIONS AND MODIFICATIONS TO STANDARDS.—

''(A) IN GENERAL.—For purposes of paragraph (1), the Secretary shall provide for an expedited upgrade program (in this paragraph referred to as the 'upgrade program'), in accordance with this paragraph, to develop and approve additions and modifications to the standards adopted under section 1173(a) to improve the quality of such standards or to extend the functionality of such standards to meet evolving requirements in health care.

''(B) PUBLICATION OF NOTICES.—Under the upgrade program:

''(i) VOLUNTARY NOTICE OF INITIATION OF PROCESS.—Not later than 30 days after the date the Secretary receives a notice from a standard setting organization that the organization is initiating a process to develop an addition or modification to a standard adopted under section 1173(a), the Secretary shall publish a notice in the Federal Register that—

''(I) identifies the subject matter of the addition or modification;

''(II) provides a description of how persons may participate in the development process; and

''(III) invites public participation in such process.

''(ii) VOLUNTARY NOTICE OF PRELIMINARY DRAFT OF ADDITIONS OR MODIFICATIONS TO STANDARDS.—Not later than 30 days after the date of the date the Secretary receives a notice from a standard setting organization that the organization has prepared a preliminary draft of an addition or modification to a standard adopted by section 1173(a), the Secretary shall publish a notice in the Federal Register that—

''(I) identifies the subject matter of (and summarizes) the addition or modification;

''(II) specifies the procedure for obtaining the draft;

''(III) provides a description of how persons may submit comments in writing and at any public hearing or meeting held by the organization on the addition or modification; and

''(IV) invites submission of such comments and participation in such hearing or meeting without requiring the public to pay a fee to participate.

''(iii) NOTICE OF PROPOSED ADDITION OR MODIFICATION TO STANDARDS.—Not later than 30 days after the date of the date the Secretary receives a notice from a standard setting organization that the organization has a proposed addition or modification to a standard adopted under section 1173(a) that the organization intends to submit under subparagraph (D)(iii), the Secretary shall publish a notice in the Federal Register that contains, with respect to the proposed addition or modification, the information required in the notice under clause (ii) with respect to the addition or modification.

''(iv) CONSTRUCTION.—Nothing in this paragraph shall be construed as requiring a standard setting organization to request the notices described in clauses (i) and (ii) with respect to an addition or modification to a standard in order to qualify for an expedited determination under subparagraph (C) with respect to a proposal submitted to the Secretary for adoption of such addition or modification.

''(C) PROVISION OF EXPEDITED DETERMINATION.—Under the upgrade program and with respect to a proposal by a standard setting organization for an addition or modification to a standard adopted under section 1173(a), if the Secretary determines that the standard setting organization developed such addition or modification in accordance with the requirements of subparagraph (D) and the National Committee on Vital and Health Statistics recommends approval of such addition or modification under subparagraph (E), the Secretary shall provide for expedited treatment of such proposal in accordance with subparagraph (F).

''(D) REQUIREMENTS.—The requirements under this subparagraph with respect to a proposed addition or modification to a standard by a standard setting organization are the following:

''(i) REQUEST FOR PUBLICATION OF NOTICE.—The standard setting organization submits to the Secretary a request for publication in the Federal Register of a notice described in subparagraph (B)(iii) for the proposed addition or modification.

''(ii) PROCESS FOR RECEIPT AND CONSIDERATION OF PUBLIC COMMENT.—The standard setting organization provides for a process through which, after the publication of the notice referred to under clause (i), the organization—

''(I) receives and responds to public comments submitted on a timely basis on the proposed addition or modification before submitting such proposed addition or modification to the National Committee on Vital and Health Statistics under clause (iii);

''(II) makes publicly available a written explanation for its response in the proposed addition or modification to comments submitted on a timely basis; and

''(III) makes public comments received under clause (I) available, or provides access to such comments, to the Secretary.

''(iii) SUBMITTAL OF FINAL PROPOSED ADDITION OR MODIFICATION TO NCVHS.—After completion of the process under clause (ii), the standard setting organization submits the proposed addition or modification to the National Committee on Vital and Health Statistics for review and consideration under subparagraph (E). Such submission shall include information on the organization's compliance with the notice and comment requirements (and responses to those comments) under clause (ii).

''(E) HEARING AND RECOMMENDATIONS BY NATIONAL COMMITTEE ON VITAL AND HEALTH STATISTICS.—Under the upgrade program, upon receipt of a proposal submitted by a standard setting organization under subparagraph (D)(iii) for the adoption of an addition or modification to a standard, the National Committee on Vital and Health Statistics shall provide notice to the public and a reasonable opportunity for public testimony at a hearing on such addition or modification. The Secretary may participate in such hearing in such capacity (including presiding ex officio) as the Secretary shall determine appropriate. Not later than 120 days after the date of receipt of the proposal, the Committee shall submit to the Secretary its recommendation to adopt (or not adopt) the proposed addition or modification.

''(F) DETERMINATION BY SECRETARY TO ACCEPT OR REJECT NATIONAL COMMITTEE ON VITAL AND HEALTH STATISTICS RECOMMENDATION.—

''(i) TIMELY DETERMINATION.—Under the upgrade program, if the National Committee on Vital and Health Statistics submits to the Secretary a recommendation under subparagraph (E) to adopt a proposed addition or modification, not later than 90 days after the date of receipt of such recommendation the Secretary shall make a determination to accept or reject the recommendation and shall publish notice of such determination in the Federal Register not later than 30 days after the date of the determination.

''(ii) CONTENTS OF NOTICE.—If the determination is to reject the recommendation, such notice shall include the reasons for the rejection. If the determination is to accept the recommendation, as part of such notice the Secretary shall promulgate the modified standard (including the accepted proposed addition or modification accepted) as a final rule under this subsection without any further notice or public comment period.

''(iii) LIMITATION ON CONSIDERATION.—The Secretary shall not consider a proposal under this subparagraph unless the Secretary determines that the requirements of subparagraph (D) (including publication of notice and opportunity for public comment) have been met with respect to the proposal.

''(G) EXEMPTION FROM PAPERWORK REDUCTION ACT.—Chapter 35 of title 44, United States Code, shall not apply to a final rule promulgated under subparagraph (F).

''(H) TREATMENT AS SATISFYING REQUIREMENTS FOR NOTICE-AND-COMMENT.—Any requirements under section 553 of title 5, United States Code, relating to notice and an opportunity for public comment with respect to a final rule promulgated under subparagraph (F) shall be treated as having been met by meeting the requirements of the notice and opportunity for public comment provided under provisions of subparagraphs (B)(iii), (D), and (E).

''(I) NO JUDICIAL REVIEW.—A final rule promulgated under subparagraph (F) shall not be subject to judicial review.''.

SEC. 202. UPGRADING ASC X12 AND NCPDP STANDARDS.

(a) IN GENERAL.—The Secretary of Health and Human Services shall provide by notice published in the Federal Register for the following replacements of standards to apply to transactions occurring on or after April 1, 2009:

(1) ACCREDITED STANDARDS COMMITTEE X12 (ASC X12) STANDARD.—The replacement of the Accredited Standards Committee X12 (ASC X12) version 4010 adopted under section 1173(a) of such Act (42 U.S.C. 1320d-2(a)) with the ASC X12 version 5010, as reviewed by the National Committee on Vital Health Statistics.

(2) NATIONAL COUNCIL FOR PRESCRIPTION DRUG PROGRAMS (NCPDP) TELECOMMUNICATIONS STANDARDS.—The replacement of the National Council for Prescription Drug Programs (NCPDP) Telecommunications Standards version 5.1 adopted under section 1173(a) of such Act (42 U.S.C. 1320d–2(a)) with whichever is the latest version of the NCPDP Telecommunications Standards that has been approved by such Council and reviewed by the National Committee on Vital Health Statistics as of April 1, 2007.

(b) NO JUDICIAL REVIEW.—The implementation of subsection (a), including the determination of the latest version under subsection (a)(2), shall not be subject to judicial review.

SEC. 203. UPGRADING ICD CODES; CODING AND DOCUMENTATION OF NON-MEDICAL INFORMATION.

(a) UPGRADING ICD CODES.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall provide by notice published in the Federal Register for the replacement of the International Classification of Diseases, 9th revision, Clinical Modification (ICD–9-CM) under the regulation promulgated under section 1173(c) of the Social Security Act (42 U.S.C. 1320d–2(c)), including for purposes of part A of title XVIII of such Act, with both of the following:

(A) The International Classification of Diseases, 10th revision, Clinical Modification (ICD–10-CM).

(B) The International Classification of Diseases, 10th revision, Procedure Coding System (ICD–10-PCS).

(2) APPLICATION.—The replacement made by paragraph (1) shall apply, for purposes of section 1175(b)(2) of the Social Security Act (42 U.S.C. 1320d–4(b)(2)), to services furnished on or after October 1, 2010.

(3) RULES OF CONSTRUCTION.—Nothing in paragraph (1) shall be construed—

(A) as affecting the application of classification methodologies or codes, such as CPT or HCPCS codes, other than under the International Classification of Diseases (ICD); or

(B) as superseding the authority of the Secretary of Health and Human Services to maintain and modify the coding set for ICD–10-CM and ICD–10-PCS, including under the amendments made by section 201.

(b) CODING AND DOCUMENTATION OF NON-MEDICAL INFORMATION.—In any regulation or other action implementing the International Classification of Diseases, 10th revision, Clinical Modification (ICD–10-CM), the International Classification of Diseases, 10th revision, Procedure Coding System (ICD–10-PCS), or other version of the International Classification of Diseases, 10th revision, the Secretary of Health and Human Services shall ensure that no health care provider is required to code to a level of specificity that would require documentation of non-medical information on the external cause of any given type of injury.

SEC. 204. STRATEGIC PLAN FOR COORDINATING IMPLEMENTATION OF TRANSACTION STANDARDS AND ICD CODES.

Not later than the date that is 180 days after the date of the enactment of this Act, the Secretary of Health and Human Services, in consultation with relevant public and private entities, shall develop a strategic plan with respect to the need for coordination in the implementation of—

(1) transaction standards under section 1173(a) of the Social Security Act, including modifications to such standards under section 1174(b)(3) of such Act, as added by section 201; and

(2) any updated versions of the International Classification of Diseases (ICD), including the replacement of ICD–9 provided for under section 203(a).

SEC. 205. STUDY AND REPORT TO DETERMINE IMPACT OF VARIATION AND COMMONALITY IN STATE HEALTH INFORMATION LAWS AND REGULATIONS.

Part C of title XI of the Social Security Act is amended by adding at the end the following new section:

''STUDY AND REPORT TO DETERMINE IMPACT OF VARIATION AND COMMONALITY IN STATE HEALTH INFORMATION LAWS AND REGULATIONS

''SEC. 1180. (a) STUDY.—For purposes of promoting the development of a nationwide interoperable health information technology infrastructure consistent with section 271(b) of the Public Health Service Act, the Secretary shall conduct a study of the impact of variation in State security and confidentiality laws and current Federal security and confidentiality standards on the timely exchanges of health information in order to ensure the availability of health information necessary to make medical decisions at the location in which the medical care involved is provided. Such study shall examine—

''(1)(A) the degree of variation and commonality among the requirements of such laws for States; and

''(B) the degree of variation and commonality between the requirements of such laws and the current Federal standards;

''(2) insofar as there is variation among and between such requirements, the strengths and weaknesses of such requirements; and

''(3) the extent to which such variation may adversely impact the secure, confidential, and timely exchange of health information among States, the Federal government, and public and private entities, or may otherwise impact the reliability of such information.

''(b) REPORT.—Not later than 18 months after the date of the enactment of this section, the Secretary shall submit to Congress a report on the study under subsection (a) and shall include in such report the following:

''(1) ANALYSIS OF NEED FOR GREATER COMMONALITY.—A determination by the Secretary on the extent to which there is a need for greater commonality of the requirements of State security and confidentiality laws and current Federal security and confidentiality standards to better protect, strengthen, or otherwise improve the secure, confidential, and timely exchange of health information among States, the Federal government, and public and private entities.

''(2) RECOMMENDATIONS FOR GREATER COMMONALITY.—Insofar as the Secretary determines under paragraph (1) that there is a need for greater commonality of such requirements, recommendations on the extent to which (and how) the current Federal security and confidentiality standards should be changed in order to provide the commonality needed to better protect, strengthen, or otherwise improve the secure, confidential, and timely exchange of health information.

''(3) SPECIFIC RECOMMENDATION ON LEGISLATIVE CHANGES FOR GREATER COMMONALITY.—A specific recommendation on the extent to which and how such standards should supersede State laws, in order to provide the commonality needed to better protect or strengthen the security and confidentiality of health information in the timely exchange of such information and legislative language in the form of a bill to effectuate such specific recommendation.

''(c) CONGRESSIONAL CONSIDERATION OF LEGISLATION PROVIDING FOR GREATER COMMONALITY.—

''(1) RULES OF HOUSE OF REPRESENTATIVES AND SENATE.—This subsection is enacted by the Congress—

''(A) as an exercise of the rulemaking power of the House of Representatives and the Senate, respectively, and as such they are deemed a part of the rules of each House, respectively, but applicable only with respect to the procedure to be followed in that House in the case of a greater commonality bill defined in paragraph (4), and they supersede other rules only to the extent that they are inconsistent therewith; and

''(B) with full recognition of the constitutional right of either House to change the rules (so far as relating to the procedure of that House) at any time, in the same manner and to the same extent as in the case of any other rule of that House.

''(2) INTRODUCTION.—On the date on which the final report is submitted under subsection (b)(3)—

''(A) a greater commonality bill shall be introduced (by request) in the House by the majority leader of the House, for himself and the minority leader of the House, or by Members of the House designated by the majority leader and minority leader of the House; and

''(B) a greater commonality bill shall be introduced (by request) in the Senate by the majority leader of the Senate, for himself and the minority leader of the Senate, or by Members of the Senate designated by the majority leader and minority leader of the Senate.

If either House is not in session on the day on which such a report is submitted, the greater commonality bill shall be introduced in that House, as provided in the preceding sentence, on the first day thereafter on which the House is in session.

''(3) REFERRAL.—A greater commonality bill shall be referred by the Presiding Officers of the respective House to the appropriate committee (or committees) of such House, in accordance with the rules of that House.

''(4) GREATER COMMONALITY BILL DEFINED.—For purposes of this section, the term 'greater commonality bill' means a bill—

''(A) the title of which is the following: 'A Bill to provide the commonality needed to better protect, strengthen, or otherwise improve the secure, confidential, and timely exchange of health information'; and

''(B) the text of which, as introduced, consists of the text of the bill included in the report submitted under subsection (b)(3).

''(d) DEFINITIONS.—For purposes of this section:

''(1) CURRENT FEDERAL SECURITY AND CONFIDENTIALITY STANDARDS.—The term 'current Federal security and confidentiality standards' means the Federal privacy standards established pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note) and security standards established under section 1173(d) of the Social Security Act.

''(2) STATE.—The term 'State' has the meaning given such term when used in title XI of the Social Security Act, as provided under section 1101(a) of such Act (42 U.S.C. 1301(a)).

''(3) STATE SECURITY AND CONFIDENTIALITY LAWS.—The term 'State security and confidentiality laws' means State laws and regulations relating to the privacy and confidentiality of health information or to the security of such information.''.

TITLE III—PROMOTING THE USE OF HEALTH INFORMATION TECHNOLOGY TO BETTER COORDINATE HEALTH CARE

SEC. 301. SAFE HARBORS TO ANTIKICKBACK CIVIL PENALTIES AND CRIMINAL PENALTIES FOR PROVISION OF HEALTH INFORMATION TECHNOLOGY AND TRAINING SERVICES.

(a) FOR CIVIL PENALTIES.—Section 1128A of the Social Security Act (42 U.S.C. 1320a–7a) is amended—

(1) in subsection (b), by adding at the end the following new paragraph:

''(4) For purposes of this subsection, inducements to reduce or limit services described in paragraph (1) shall not include the practical or other advantages resulting from health information technology or related installation, maintenance, support, or training services.''; and

(2) in subsection (i), by adding at the end the following new paragraph:

''(8) The term 'health information technology' means hardware, software, license, right, intellectual property, equipment, or other information technology (including new versions, upgrades, and connectivity) designed or provided primarily for the electronic creation, maintenance, or exchange of health information to better coordinate care or improve health care quality, efficiency, or research.''.

(b) FOR CRIMINAL PENALTIES.—Section 1128B of such Act (42 U.S.C. 1320a–7b) is amended—

(1) in subsection (b)(3)—

(A) in subparagraph (G), by striking ''and'' at the end;

(B) in the subparagraph (H) added by section 237(d) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2213)—

(i) by moving such subparagraph 2 ems to the left; and

(ii) by striking the period at the end and inserting a semicolon;

(C) in the subparagraph (H) added by section 431(a) of such Act (117 Stat. 2287)—

(i) by redesignating such subparagraph as subparagraph (I);

(ii) by moving such subparagraph 2 ems to the left; and

(iii) by striking the period at the end and inserting ''; and''; and

(D) by adding at the end the following new subparagraph:

''(J) any nonmonetary remuneration (in the form of health information technology, as defined in section 1128A(i)(8), or related installation, maintenance, support or training services) made to a person by a specified entity (as defined in subsection (g)) if—

''(i) the provision of such remuneration is without an agreement between the parties or legal condition that—

''(I) limits or restricts the use of the health information technology to services provided by the physician to individuals receiving services at the specified entity;

''(II) limits or restricts the use of the health information technology in conjunction with other health information technology; or

''(III) conditions the provision of such remuneration on the referral of patients or business to the specified entity;

''(ii) such remuneration is arranged for in a written agreement that is signed by the parties involved (or their representatives) and that specifies the remuneration solicited or received (or offered or paid) and states that the provision of such remuneration is made for the primary purpose of better coordination of care or improvement of health quality, efficiency, or research; and

''(iii) the specified entity providing the remuneration (or a representative of such entity) has not taken any action to disable any basic feature of any hardware or software component of such remuneration that would permit interoperability.''; and

(2) by adding at the end the following new subsection:

''(g) SPECIFIED ENTITY DEFINED.—For purposes of subsection (b)(3)(J), the term 'specified entity' means an entity that is a hospital, group practice, prescription drug plan sponsor, a Medicare Advantage organization, or any other such entity specified by the Secretary, considering the goals and objectives of this section, as well as the goals to better coordinate the delivery of health care and to promote the adoption and use of health information technology.''.

(c) EFFECTIVE DATE AND EFFECT ON STATE LAWS.—

(1) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) shall take effect on the date that is 120 days after the date of the enactment of this Act.

(2) PREEMPTION OF STATE LAWS.—No State (as defined in section 1101(a) of the Social Security Act (42 U.S.C. 1301(a)) for purposes of title XI of such Act) shall have in effect a State law that imposes a criminal or civil penalty for a transaction described in section 1128A(b)(4) or section 1128B(b)(3)(J) of such Act, as added by subsections (a)(1) and (b), respectively, if the conditions described in the respective provision, with respect to such transaction, are met.

(d) STUDY AND REPORT TO ASSESS EFFECT OF SAFE HARBORS ON HEALTH SYSTEM.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall conduct a study to determine the impact of each of the safe harbors described in paragraph (3). In particular, the study shall examine the following:

(A) The effectiveness of each safe harbor in increasing the adoption of health information technology.

(B) The types of health information technology provided under each safe harbor.

(C) The extent to which the financial or other business relationships between providers under each safe harbor have changed as a result of the safe harbor in a way that adversely affects or benefits the health care system or choices available to consumers.

(D) The impact of the adoption of health information technology on health care quality, cost, and access under each safe harbor.

(2) REPORT.—Not later than three years after the effective date described in subsection (c)(1), the Secretary of Health and Human Services shall submit to Congress a report on the study under paragraph (1).

(3) SAFE HARBORS DESCRIBED.—For purposes of paragraphs (1) and (2), the safe harbors described in this paragraph are—

(A) the safe harbor under section 1128A(b)(4) of such Act (42 U.S.C. 1320a–7a(b)(4)), as added by subsection (a)(1); and

(B) the safe harbor under section 1128B(b)(3)(J) of such Act (42 U.S.C. 1320a–7b(b)(3)(J)), as added by subsection (b).

SEC. 302. EXCEPTION TO LIMITATION ON CERTAIN PHYSICIAN REFERRALS (UNDER STARK) FOR PROVISION OF HEALTH INFORMATION TECHNOLOGY AND TRAINING SERVICES TO HEALTH CARE PROFESSIONALS.

(a) IN GENERAL.—Section 1877(b) of the Social Security Act (42 U.S.C. 1395nn(b)) is amended by adding at the end the following new paragraph:

''(6) INFORMATION TECHNOLOGY AND TRAINING SERVICES.—

''(A) IN GENERAL.—Any nonmonetary remuneration (in the form of health information technology or related installation, maintenance, support or training services) made by a specified entity to a physician if—

''(i) the provision of such remuneration is without an agreement between the parties or legal condition that—

''(I) limits or restricts the use of the health information technology to services provided by the physician to individuals receiving services at the specified entity;

''(II) limits or restricts the use of the health information technology in conjunction with other health information technology; or

''(III) conditions the provision of such remuneration on the referral of patients or business to the specified entity;

''(ii) such remuneration is arranged for in a written agreement that is signed by the parties involved (or their representatives) and that specifies the remuneration made and states that the provision of such remuneration is made for the primary purpose of better coordination of care or improvement of health quality, efficiency, or research; and

''(iii) the specified entity (or a representative of such entity) has not taken any action to disable any basic feature of any hardware or software component of such remuneration that would permit interoperability.

''(B) HEALTH INFORMATION TECHNOLOGY DEFINED.—For purposes of this paragraph, the term 'health information technology' means hardware, software, license, right, intellectual property, equipment, or other information technology (including new versions, upgrades, and connectivity) designed or provided primarily for the electronic creation, maintenance, or exchange of health information to better coordinate care or improve health care quality, efficiency, or research.

''(C) SPECIFIED ENTITY DEFINED.—For purposes of this paragraph, the term 'specified entity' means an entity that is a hospital, group practice, prescription drug plan sponsor, a Medicare Advantage organization, or any other such entity specified by the Secretary, considering the goals and objectives of this section, as well as the goals to better coordinate the delivery of health care and to promote the adoption and use of health information technology.''.

(b) EFFECTIVE DATE; EFFECT ON STATE LAWS.—

(1) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date that is 120 days after the date of the enactment of this Act.

(2) PREEMPTION OF STATE LAWS.—No State (as defined in section 1101(a) of the Social Security Act (42 U.S.C. 1301(a)) for purposes of title XI of such Act) shall have in effect a State law that imposes a criminal or civil penalty for a transaction described in section 1877(b)(6) of such Act, as added by subsection (a), if the conditions described in such section, with respect to such transaction, are met.

(c) STUDY AND REPORT TO ASSESS EFFECT OF EXCEPTION ON HEALTH SYSTEM.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall conduct a study to determine the impact of the exception under section 1877(b)(6) of such Act (42 U.S.C. 1395nn(b)(6)), as added by subsection (a). In particular, the study shall examine the following:

(A) The effectiveness of the exception in increasing the adoption of health information technology.

(B) The types of health information technology provided under the exception.

(C) The extent to which the financial or other business relationships between providers under the exception have changed as a result of the exception in a way that adversely affects or benefits the health care system or choices available to consumers.

(D) The impact of the adoption of health information technology on health care quality, cost, and access under the exception.

(2) REPORT.—Not later than three years after the effective date described in subsection (b)(1), the Secretary of Health and Human Services shall submit to Congress a report on the study under paragraph (1).

SEC. 303. RULES OF CONSTRUCTION REGARDING USE OF CONSORTIA.

(a) APPLICATION TO SAFE HARBOR FROM CRIMINAL PENALTIES.—Section 1128B(b)(3) of the Social Security Act (42 U.S.C. 1320a–7b(b)(3)) is amended by adding after and below subparagraph (J), as added by section 301(b)(1), the following: ''For purposes of subparagraph (J), nothing in such subparagraph shall be construed as preventing a specified entity, consistent with the specific requirements of such subparagraph, from forming a consortium composed of health care providers, payers, employers, and other interested entities to collectively purchase and donate health information technology, or from offering health care providers a choice of health information technology products in order to take into account the varying needs of such providers receiving such products.''.

(b) APPLICATION TO STARK EXCEPTION.—Paragraph (6) of section 1877(b) of the Social Security Act (42 U.S.C. 1395nn(b)), as added by section 302(a), is amended by adding at the end the following new subparagraph:

''(D) RULE OF CONSTRUCTION.—For purposes of subparagraph (A), nothing in such subparagraph shall be construed as preventing a specified entity, consistent with the specific requirements of such subparagraph, from—

''(i) forming a consortium composed of health care providers, payers, employers, and other interested entities to collectively purchase and donate health information technology; or

''(ii) offering health care providers a choice of health information technology products in order to take into account the varying needs of such providers receiving such products.''.

TITLE IV—ADDITIONAL PROVISIONS

SEC. 401. PROMOTION OF TELEHEALTH SERVICES.

(a) FACILITATING THE PROVISION OF TELEHEALTH SERVICES ACROSS STATE LINES.—The Secretary of Health and Human Services shall, in coordination with physicians, health care practitioners, patient advocates, and representatives of States, encourage and facilitate the adoption of State reciprocity agreements for practitioner licensure in order to expedite the provision across State lines of telehealth services.

(b) REPORT.—Not later than 18 months after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to Congress a report on the actions taken to carry out subsection (a).

(c) STATE DEFINED.—For purposes of this subsection, the term ''State'' has the meaning given that term for purposes of title XVIII of the Social Security Act.

SEC. 402. STUDY AND REPORT ON EXPANSION OF HOME HEALTH-RELATED TELEHEALTH SERVICES.

(a) STUDY.—The Secretary of Health and Human Services shall conduct a study to determine the feasibility, advisability, and the costs of—

(1) including coverage and payment for home health-related telehealth services as part of home health services under title XVIII of the Social Security Act; and

(2) expanding the list of sites described in paragraph (4)(C)(ii) of section 1834(m) of the Social Security Act (42 U.S.C. 1395m(m)) to include county mental health clinics or other publicly funded mental health facilities for the purpose of payment under such section for the provision of telehealth services at such clinics or facilities.

(b) SPECIFICS OF STUDY.—Such study shall demonstrate whether the changes described in paragraphs (1) and (2) of subsection (a) will result in the following:

(1) Enhanced health outcomes for individuals with one or more chronic conditions.

(2) Health outcomes for individuals furnished telehealth services or home health-related telehealth services that are at least comparable to the health outcomes for individuals furnished similar items and services by a health care provider at the same location of the individual or at the home of the individual, respectively.

(3) Facilitation of communication of more accurate clinical information between health care providers.

(4) Closer monitoring of individuals by health care providers.

(5) Overall reduction in expenditures for health care items and services.

(6) Improved access to health care.

(c) HOME HEALTH-RELATED TELEHEALTH SERVICES DEFINED.—For purposes of this section, the term ''home health-related telehealth services'' means technology-based professional consultations, patient monitoring, patient training services, clinical observation, patient assessment, and any other health services that utilize telecommunications technologies. Such term does not include a telecommunication that consists solely of a telephone audio conversation, facsimile, electronic text mail, or consultation between two health care providers.

(d) REPORT.—Not later than 18 months after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to Congress a report on the study conducted under subsection (a) and shall include in such report such recommendations for legislation or administration action as the Secretary determines appropriate.

SEC. 403. STUDY AND REPORT ON STORE AND FORWARD TECHNOLOGY FOR TELEHEALTH.

(a) STUDY.—The Secretary of Health and Human Services, acting through the Director of the Office for the Advancement of Telehealth, shall conduct a study on the use of store and forward technologies (that provide for the asynchronous transmission of health care information in single or multimedia formats) in the provision of telehealth services. Such study shall include an assessment of the feasibility, advisability, and the costs of expanding the use of such technologies for use in the diagnosis and treatment of certain conditions.

(b) REPORT.—Not later than 18 months after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to Congress a report on the study conducted under subsection (a) and shall include in such report such recommendations for legislation or administration action as the Secretary determines appropriate.

SEC. 404. ENSURING HEALTH CARE PROVIDERS PARTICIPATING IN PHSA PROGRAMS, MEDICAID, SCHIP, OR THE MCH PROGRAM MAY MAINTAIN HEALTH INFORMATION IN ELECTRONIC FORM.

Part D of title II of the Public Health Service Act, as added by section 101(a) and amended by sections 103 and 105, is further amended by adding at the end the following new section:

''SEC. 274. ENSURING HEALTH CARE PROVIDERS MAY MAINTAIN HEALTH INFORMATION IN ELECTRONIC FORM.

''(a) IN GENERAL.—Any health care provider that participates in a health care program that receives Federal funds under this Act, or under title V, XIX, or XXI of the Social Security Act, shall be deemed as meeting any requirement for the maintenance of data in paper form under such program (whether or not for purposes of management, billing, reporting, reimbursement, or otherwise) if the required data is maintained in an electronic form.

''(b) RELATION TO STATE LAWS.—Beginning on the date that is one year after the date of the enactment of this section, subsection (a) shall supersede any contrary provision of State law.

''(c) CONSTRUCTION.—Nothing in this section shall be construed as—

''(1) requiring health care providers to maintain or submit data in electronic form;

''(2) preventing a State from permitting health care providers to maintain or submit data in paper form; or

''(3) preventing a State from requiring health care providers to maintain or submit data in electronic form.''.

SEC. 405. ENSURING HEALTH CARE PROVIDERS PARTICIPATING IN THE MEDICARE PROGRAM MAY MAINTAIN HEALTH INFORMATION IN ELECTRONIC FORM.

Section 1871 of the Social Security Act (42 U.S.C. 1395hh) is amended by adding at the end the following new subsection:

''(g)(1) Any provider of services or supplier shall be deemed as meeting any requirement for the maintenance of data in paper form under this title (whether or not for purposes of management, billing, reporting, reimbursement, or otherwise) if the required data is maintained in an electronic form.

''(2) Nothing in this subsection shall be construed as requiring health care providers to maintain or submit data in electronic form.''.

SEC. 406. STUDY AND REPORT ON STATE, REGIONAL, AND COMMUNITY HEALTH INFORMATION EXCHANGES.

(a) STUDY.—The Secretary of Health and Human Services shall conduct a study on issues related to the development, operation, and implementation of State, regional, and community health information exchanges. Such study shall include the following, with respect to such health information exchanges:

(1) Profiles detailing the current stages of such health information exchanges with respect to the progression of the development, operation, implementation, organization, and governance of such exchanges.

(2) The impact of such exchanges on healthcare quality, safety, and efficiency, including—

(A) any impact on the coordination of health information and services across healthcare providers and other organizations relevant to health care;

(B) any impact on the availability of health information at the point-of-care to make timely medical decisions;

(C) any benefits with respect to the promotion of wellness, disease prevention, and chronic disease management;

(D) any improvement with respect to public health preparedness and response;

(E) any impact on the widespread adoption of interoperable health information technology, including electronic health records;

(F) any contributions to achieving an Internet-based national health information network;

(G) any contribution of health information exchanges to consumer access and to consumers' use of their health information; and

(H) any impact on the operation of—

(i) the Medicaid and Medicare programs;

(ii) the State Children's Health Insurance Program (SCHIP);

(iii) disproportionate share hospitals described in section 1923 of the Social Security Act;

(iv) Federally-qualified health centers; or

(v) managed care plans, if a significant number of the plan's enrollees are beneficiaries in the Medicaid program or SCHIP.

(3) Best practice models for financing, incentivizing, and sustaining such health information exchanges.

(4) Information identifying the common principles, policies, tools, and standards used (or proposed) in the public and private sectors to support the development, operation, and implementation of such health information exchanges.

(5) A description of any areas in which Federal government leadership is needed to support growth and sustainability of such health information exchanges.

(b) REPORT.—Not later than one year after the date of enactment of this Act, the Secretary of Health and Human Services shall submit to Congress a report on the study described in subsection (a), including such recommendations as the Secretary determines appropriate to facilitate the development, operation, and implementation of health information exchanges.

The CHAIRMAN. No further amendment to the bill, as amended, is in order except those printed in part C of the report. Each amendment may be offered only in the order printed in the report, by a member designated in the report, shall be considered read, shall be debatable for the time specified in the report, equally divided and controlled by the proponent and an opponent, shall not be subject to amendment, and shall not be subject to a demand for division of the question.

AMENDMENT NO. 1 OFFERED BY MR. HINOJOSA

The CHAIRMAN. It is now in order to consider amendment No. 1 printed in part C of House Report 109–603.

Mr. HINOJOSA. Mr. Chairman, I offer an amendment.

The CHAIRMAN. The Clerk will designate the amendment.

The text of the amendment is as follows:

Amendment No. 1 offered by Mr. HINOJOSA:

In section 271(b)(8) of the Public Health Service Act, as added by section 101(a) of the Bill, strike ''is consistent'' and insert ''provides for the confidentiality and security of individually identifiable health information, consistent''.

In section 271(b) of the Public Health Service Act, as added by section 101(a) of the Bill, strike ''and'' at the end of paragraph (11), strike the period at the end of paragraph (12) and insert ''; and'', and add at the end the following new paragraph:

''(13) improves the availability of information and resources for individuals with low or limited literacy or language skills.''.

The CHAIRMAN. Pursuant to House Resolution 952, the gentleman from Texas (Mr. HINOJOSA) and a Member opposed each will control 5 minutes.

The Chair recognizes the gentleman from Texas.

Mr. HINOJOSA. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, I rise today to offer an amendment to help ensure equal access to our health care system. All too often a lack of education can limit the quality of life of an individual. This is especially true when considering issues that govern one's health and well being.

To change this fact, I am offering an amendment that would help ensure that all citizens would benefit from advances in our medical technology and new information. My amendment directs the national coordinator for the health information technology to increase information and medical resources for individuals with low literacy.

Passage of this amendment would create a new national priority for bridging the literacy gap in health care resources and assign responsibility of that goal to the new national coordinator.

The new priority is especially important in the race to cure diabetes. In my congressional district, over 100,000 individuals suffer from this disease. And while our Nation is constantly working to find new ways of combating diabetes, most of those inventions rely heavily on medical technology that requires its users to have a certain level of mathematical skills, access to the Internet, and in some cases, at a minimum, a high school level of literacy.

While at first these requirements may seem ordinary and readily available, in districts such as mine, this is all but impossible. It is impossible because a large number of citizens who suffer from diabetes are undereducated, or they are elderly and lack computer skills. In some cases they live in poverty.

Simply put, the most effective treatments for individuals with diabetes and other illnesses remain out of the reach of citizens who need it most. Due to the lack of focus and the creation of our technology, millions die each year.

Additionally, according to a study sponsored by the American Diabetes Association, an organization that has endorsed this amendment, our Nation pays over $100 billion a year in lost wages, lost productivity, emergency room visits and care.

A clear example of what is at risk if we fail to launch an aggressive effort geared at removing literacy barriers to health care information and technology can be witnessed in my own district's 41 percent diabetes mortality rate.

That means that due to health care literacy barriers, one in two citizens diagnosed with diabetes in my district will die from diabetes complications.

To help change this fact, I urge my colleagues to support this amendment.

Mr. Chairman, may I inquire how much time I have remaining.

The CHAIRMAN. The gentleman has 2 minutes remaining.

Does any Member claim time in opposition to the amendment?

Mrs. JOHNSON of Connecticut. Mr. Chairman, I claim time in opposition to the amendment. I don't intend to oppose the amendment. I am just claiming the time.

The CHAIRMAN. Without objection, the gentlewoman from Connecticut will control 5 minutes.

There was no objection.

Mrs. JOHNSON of Connecticut. Mr. Chairman, I think the gentleman's amendment points out why health information technology is so terribly important to making the next leap forward in quality that medical science has made available to us.

It will take a lot more teaching of patients. It will take a much different relationship between nurses and medical personnel and patients to make sure that they have the guidance and support they need to prevent their disease from getting worse or to follow a regimen that will prevent their chronic illness from compromising their lives.

□ 1430

So this issue of communication is going to be a bigger issue in the next round of the American health care system even than it is today.

But I would like to yield to the gentleman from Pennsylvania for some questions.

Mr. MURPHY. I thank the gentlewoman, and I have a question for the distinguished gentleman from Texas just to help clarify this, because my assumption is the amendment would be one that would help those who have problems with illiteracy or language skills, perhaps English language is not of good grasp to them and they may be in a hospital where the staff may not be aware of that, and one of the importance of an electronic medical record is the files would be there on record. So even if the person had limited abilities, the doctor would have access. But I want to just ask a clarifying question to make sure this is what you meant by this amendment.

By this, I am assuming it is not a matter that would impede in any way the doctor's ability to have information on record, that would have swift and high standards of medical care there, in no way would this impede; such as the records would have to be written in multiple languages for doctors who wouldn't necessarily understand that. I am assuming that is the case in this, that you are saying that the best interest of the patient is what you have in mind here so that the records are always available, that the doctor could understand them clearly even if the patient has difficulty communicating. Am I correct in that, sir?

Mr. HINOJOSA. In my opinion, if the patient gives permission that that information be released, I have no problem with that.

Mr. MURPHY. I am assuming that is what you meant. It is important that hospitals not see this as something that they, for example, have to constantly rewrite records in ways that would impair understanding between physicians as well. And along those lines, I think it is an excellent idea to provide it, because it does provide access of information for the doctors.

Mr. HINOJOSA. If the gentleman will allow me to explain. I think that the intent of my amendment is to be able to acknowledge that there are people out there who can not get one of these new machines that we use now to measure the glucose, if I am a diabetic, and be able to take it and follow the instructions if they are limited English proficient, for example. In many cases, the lower the level of education attainment, the more difficult it is to use some of this modern equipment that is available in technology. And so the intent of Congress would be to address that group, regardless of the size, the percentage of people who need that extra assistance with the training necessary to use the modern equipment.

Mr. MURPHY. Reclaiming my time, that makes sense, because I work with many patients who are disabled, who have literacy problems, and it is important that the medical community works to help those patients. I just want to make sure also the electronic medical records then serve both purposes, to help those patients, but certainly to make sure the primary aspects of having the medical records there electronically is to help doctors communicate quickly and swiftly with accurate data. Along those lines, I think it is an excellent idea.

Mr. HINOJOSA. Mr. Chairman, I would like to hear Congresswoman NANCY JOHNSON's thoughts on being able to work with us on this amendment, because it is very important not only in South Texas, but throughout the country.

Mrs. JOHNSON of Connecticut. Mr. Chairman, we certainly are willing to accept the gentleman's amendment. It is a very thoughtful and important one.

Mr. HINOJOSA. I thank the gentlewoman for accepting this amendment and working with me to eliminate the literacy barriers from our health care system.

Mr. Chairman, I yield back the balance of my time.

Mrs. JOHNSON of Connecticut. Mr. Chairman, I yield back the balance of my time.

The CHAIRMAN. The question is on the amendment offered by the gentleman from Texas (Mr. HINOJOSA).

The amendment was agreed to.

AMENDMENT NO. 2 OFFERED BY MR. TOWNS

The CHAIRMAN. It is now in order to consider amendment No. 2 printed in part C of House Report 109–603.

Mr. TOWNS. Mr. Chairman, I offer an amendment.

The CHAIRMAN. The Clerk will designate the amendment.

The text of the amendment is as follows:

Amendment No. 2 offered by Mr. TOWNS:

Add at the end of section 101 the following:

(d) STUDY OF HEALTH INFORMATION TECHNOLOGY IN MEDICALLY UNDERSERVED COMMUNITIES.—

(1) STUDY.—The National Coordinator for Health Information Technology shall conduct a study on the development and implementation of health information technology in medically underserved communities. The study shall—

(A) identify barriers to successful implementation of health information technology in these communities;

(B) examine the impact of health information technology on providing quality care and reducing the cost of care to these communities;

(C) examine urban and rural community health systems and determine the impact that health information technology may have on the capacity of primary health providers; and

(D) assess the feasibility and the costs associated with the use of health information technology in these communities.

(2) REPORT.—Not later than 18 months after the date of the enactment of this Act, the National Coordinator shall submit to Congress a report on the study conducted under paragraph (1) and shall include in such report such recommendations for legislation or administrative action as the Coordinator determines appropriate.

The CHAIRMAN. Pursuant to House Resolution 952, the gentleman from New York (Mr. TOWNS) and a Member opposed each will control 5 minutes.

The Chair recognizes the gentleman from New York.

Mr. TOWNS. Mr. Chairman, I am really concerned that, in implementing any health information technology initiative, that we will not have the best information to address the needs of medically underserved areas. My amendment to H.R. 4157 creates a critically important study that would give us the benchmarks to use in implementing this technology in these communities, both urban and rural.

First, the proposed study will examine and determine the impact of health information technology on improving the capacity of primary care providers in medically underserved communities.

Second, the study would identify the barriers to the implementation of health information technology in these communities.

Third, the study will assess the feasibility and costs associated with implementing health information technology in these communities.

Some of the Nation's finest foundations have done tremendous work in how health information technology can be used in hard-to-reach and difficult areas to serve in our Nation. They include the Markle Foundation, the Robert Wood Johnson Foundation, and the Henry J. Kaiser Family Foundation. We want to incorporate this work and other's work done by the Agency For Health Care Research and Quality, and make sure it is applied to the development and implementation of health information technology and medically underserved areas.

For these reasons, Mr. Speaker, I believe that this study is vital to the assessment, examination, and implementation of health information, technology in medically underserved areas in this Nation. And I do believe that my amendment adds considerable value to the health information technology bill. I have worked in a bipartisan fashion on this bill with Representative FERGUSON of New Jersey to present the portion of the bill related to grants in medically underserved areas.

Mr. Chairman, I do feel that this amendment strengthens this bill and is something that we really need to do if we want to reach the hard-to-reach areas and to be able to have the kind of data and have the kind of information to give them quality health care.

On that note, Mr. Chairman, I reserve the balance of my time.

The CHAIRMAN. Who claims time in opposition?

Mrs. JOHNSON of Connecticut. I rise to support this amendment.

The CHAIRMAN. Does the gentlewoman claim time in opposition?

Mrs. JOHNSON of Connecticut. I claim time in opposition.

The CHAIRMAN. Without objection, the gentlewoman will control 5 minutes.

There was no objection.

Mrs. JOHNSON of Connecticut. I claim time to say we accept the amendment. It is a very thoughtful amendment and an important one, and we thank the gentleman from New York (Mr. TOWNS).

Mr. TOWNS. I want to thank the gentlewoman from Connecticut for supporting the amendment.

Mr. Chairman, I yield back the balance of my time,

Mrs. JOHNSON of Connecticut. Mr. Chairman, I yield back the balance of my time.

The CHAIRMAN. The question is on the amendment offered by the gentleman from New York (Mr. TOWNS).

The question was taken; and the Chairman announced that the ayes appeared to have it.

Mr. PALLONE. Mr. Chairman, I demand a recorded vote.

The CHAIRMAN. Pursuant to clause 6 of rule XVIII, further proceedings on the amendment offered by the gentleman from New York will be postponed.

AMENDMENT NO. 3 OFFERED BY MR. JACKSON OF ILLINOIS

The CHAIRMAN. It is now in order to consider amendment No. 3 printed in part C of House Report 109–603.

Mr. JACKSON of Illinois. Mr. Chairman, I offer an amendment.

The CHAIRMAN. The Clerk will designate the amendment.

The text of the amendment is as follows:

Amendment No. 3 offered by Mr. JACKSON of Illinois:

In section 102, add at the end the following new paragraph:

(5) Recommendations on the inclusion of emergency contact or next-of-kin information (including name and phone number) in interoperable electronic health records.

The CHAIRMAN. Pursuant to House Resolution 952, the gentleman from Illinois (Mr. JACKSON) and a Member opposed each will control 5 minutes.

The Chair recognizes the gentleman from Illinois.

Mr. JACKSON of Illinois. Mr. Chairman, my amendment simply states that emergency contact or next-of-kin information should be included in the interoperable electronic health records.

Mr. Chairman, in an instant, a wrong turn, a sudden fall, a missed step, someone, indeed anyone, can find themselves in a crisis and in need of emergency medical care. Nationwide, nearly 1 million people arrive in emergency rooms each year unconscious or physically unable to give informed consent for their care.

Consider the story of Elaine Sullivan. A very active 71-year-old woman, Elaine fell at home while trying to get into her bathtub. When paramedics arrived, she realized that injuries to her mouth and head made her unable to communicate and give informed consent for her own care. Although stable for the first few days, she began to slip into critical condition. The hospital failed to notify her family for 6 days, and tragically Elaine Sullivan died alone in the hospital.

In the aftermath of this tragedy, Elaine Sullivan's daughter, Jan, and granddaughter, Laura, turned their personal pain to public action. Jan and Laura Greenwald went to work to make sure that that never happened to their loved ones or anyone else's loved one again.

In Elaine Sullivan's memory and honor, I introduced H.R. 2560 so that in the future phone calls to loved ones will always be made. This amendment, Mr. Chairman, which includes a provision of H.R. 2560, is a modest step to ensure that this situation doesn't happen again.

Let me be clear. Most hospitals notify the next of kin of unconscious emergency room arrivals relatively quickly. However, emergency rooms are extremely high pressure and sometimes chaotic environments. In the hustle and bustle of the ER, despite the professionalism and the dedication of staff, there are real risks that a simple phone call may or may not be able to be made in a timely fashion.

Consider for a moment just one distressing but relevant scenario. Your loved one is out of town on a business trip. On the way they are involved in a serious head-on collision, unconscious and unable to communicate. They are rushed to the nearest hospital, and unbeknownst to you they lie comatose fighting for their life miles from home. Doctors and nurses work feverishly to provide emergency medical care to a patient who is only the name on a license, but to you they are the love of your life.

If your electronic health records contained emergency contact or next-of-kin information, this could help hospital staff quickly notify you about your loved one's condition. You could rush to be by their side and possibly share critical medical history and information. Emergency contact and next-of-kin information should be included in electronic medical records to ensure that family members are notified and informed decisions are made during a medical emergency.

Mr. Chairman, I ask for an ''aye'' vote on the Jackson amendment.

Mr. Chairman, I reserve the balance of my time.

The CHAIRMAN. Does the gentlewoman from Connecticut claim the time in opposition?

Mrs. JOHNSON of Connecticut. Mr. Chairman, I rise in opposition.

The CHAIRMAN. Without objection, the gentlewoman from Connecticut will control 5 minutes.

There was no objection.

Mrs. JOHNSON of Connecticut. First of all, the gentleman from Illinois has brought a very thoughtful amendment to this bill. The information that he wants included in electronic health record is extremely important information, and I support your amendment.

Mr. JACKSON of Illinois. I thank the gentlewoman for supporting our amendment, Mr. Chairman.

I yield back the balance of my time.

The CHAIRMAN. The question is on the amendment offered by the gentleman from Illinois (Mr. JACKSON).

The amendment was agreed to.

AMENDMENT NO. 4 OFFERED BY MR. CUELLAR

The CHAIRMAN. It is now in order to consider amendment No. 4 printed in part C of House Report 109–603.

Mr. CUELLAR. Mr. Chairman, I offer an amendment.

The CHAIRMAN. The Clerk will designate the amendment.

The text of the amendment is as follows:

Amendment No. 4 printed in House Report 109–603 offered by Mr. CUELLAR:

In section 330M(d) of the Public Health Service Act, as added by section 104 of the Bill, strike ''or'' at the end of paragraph (1), strike the period at the end of paragraph (2) and insert ''; or'', and add at the end the following new paragraph:

''(3) if the project to be funded through such a grant will emphasize the improvement of access to medical care and medical care for medically underserved populations which are geographically isolated or located in underserved urban areas.''.

The CHAIRMAN. Pursuant to House Resolution 952, the gentleman from Texas (Mr. CUELLAR) and a Member opposed each will control 5 minutes.

The Chair recognizes the gentleman from Texas.

Mr. CUELLAR. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, my amendment to H.R. 4157 emphasizes the priority of funding grants which would improve access, coordination, and the provision of health care to the uninsured, underinsured, and medically underserved areas in both rural and urban areas in the State and in the country.

This amendment will add priority antiquated health system grant proposals which improve medical care access and health care by way of health information technology to patients in underserved rural and urban areas. In my district, which encompasses both rural and urban areas, I have seen the need for health IT to promote better health care and accessibility.

In some of my rural counties, citizens are faced with few health care options and in many cases, are forced to travel great distances to see doctors, specialists, and go to a hospital or care facility which can address their individual health needs. In my hometown of Laredo, Texas, a major South Texas urban area, there is a great need for health IT to better coordinate and provide the care to the uninsured and underinsured, and of course, the underserved patients.

Citizens in America's remote and rural isolated areas and urban areas, which often lack sufficient medical services, face very difficult challenges to access quality health care and treatment. New health information technology, including the health IT to be funded by grants to be integrated with the health care systems, and this particular bill, a bill that I support, lays the essential groundwork for a new era of sensibility and quality health care that all Americans deserve regardless of where they call home.

Mr. Chairman, I ask for favorable consideration of my amendment, and I believe this amendment is acceptable to Mrs. JOHNSON.

Mrs. JOHNSON of Connecticut. Mr. Chairman, I rise in support of the amendment. I understand there are some technical adjustments that your staff and our staff talked about that we will work on.

Mr. CUELLAR. And I will work with your staff in conference committee to address those technical points. I am in agreement with that. I believe my staff has been working with your staff.

Mrs. JOHNSON of Connecticut. With that understanding, I am pleased to support the gentleman's amendment.

Mr. CUELLAR. I thank the gentlewoman.

Mr. Chairman, I yield back the balance of my time.

The CHAIRMAN. Does any Member claim time in opposition to the amendment?

The question is on the amendment offered by the gentleman from Texas (Mr. CUELLAR).

The amendment was agreed to.

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AMENDMENT NO. 5 OFFERED BY MR. PRICE OF GEORGIA

The CHAIRMAN. It is now in order to consider amendment No. 5 printed in part C of House Report 109–603.

Mr. PRICE of Georgia. Mr. Chairman, I offer an amendment.

The CHAIRMAN. The Clerk will designate the amendment.

The text of the amendment is as follows:

Amendment No. 5 offered by Mr. PRICE of Georgia:

Add at the end of title II the following new section:

SEC. 206. REPORT ON APPROPRIATENESS OF CLASSIFICATION METHODOLOGIES AND CODES FOR ADDITIONAL PURPOSES.

Not later than the date that is 180 days after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to Congress a report that evaluates—

(1) the applicability of health care classification methodologies and codes for purposes beyond the coding of services for diagnostic documentation or billing purposes;

(2) the usefulness, accuracy, and completeness of such methodologies and codes for such purposes; and

(3) the capacity of such methodologies and codes to produce erroneous or misleading information, with respect to such purposes.

The CHAIRMAN. Pursuant to House Resolution 952, the gentleman from Georgia (Mr. PRICE) and a Member opposed each will control 5 minutes.

The Chair recognizes the gentleman from Georgia.

Mr. PRICE of Georgia. Mr. Chairman, I yield myself such time as I may consume.

(Mr. PRICE of Georgia asked and was given permission to revise and extend his remarks.)

Mr. PRICE of Georgia. Mr. Chairman, I rise to thank both the chairman of the committee and Chairman DREIER and the Rules Committee members.

As a physician, I know the importance of having appropriate information available in order to make quality health care decisions, and I am cautiously optimistic about the prospects in that portion of the bill.

My amendment addresses section 203, the area of the bill that seeks to upgrade the ICD codes.

ICD, or international classification of diseases, codes are diagnostic codes, series of letters and numbers that identify with some specificity the various diseases or conditions for which a patient is being treated.

ICD codes can be very useful in tracking various patients with similar conditions. They may be helpful in research that may aid in the future treatment of patients with the same disease.

ICD codes are diagnostic codes. They were intended to be used to identify as accurately as possible the diagnosis that a particular patient has.

ICD codes were not designed to be used for anything beyond documentation of a diagnosis.

However, they are being used, in combination with other codes, particularly CPT or billing codes, to evaluate various kinds of treatment and whether that treatment is appropriate or efficient or of quality.

There are many people who are providing health care for our citizens, who are taking care of our families, who have significant reservations regarding the use of those codes for purposes for which they were never designed.

It is possible that the use of these codes for other needs may, in fact, result in conclusions that are at best misleading, and worse, incorrect, thereby having the possible outcome of harming the treatment of future patients.

Consequently, my amendment calls for a report from the Secretary of Health and Human Services to Congress that would determine the applicability, usefulness, accuracy and completeness of the use of these codes.

It also asks for information on the capacity of the use of these codes to produce erroneous or misleading information.

Science relies on the accuracy of information in order to make correct judgments, determinations and decisions on how one should proceed. We here in Congress should do no less.

The consequences of our decisions can be significant, and it is imperative that we have accurate data upon which to make those decisions. The information that will result from this amendment will allow us to make those decisions with greater confidence in their benefit to our constituents.

I ask my colleagues for their support in assisting us in gaining greater insight into this important matter. I ask for their support on this amendment.

Mr. Chairman, I reserve the balance of my time.

The CHAIRMAN. Does any Member claim the time in opposition to the amendment?

Mrs. JOHNSON of Connecticut. Yes, I claim time in opposition to the amendment. Although I do not oppose the amendment, I would like to comment.

The CHAIRMAN. Without objection, the gentlewoman from Connecticut will control the time.

There was no objection.

Mrs. JOHNSON of Connecticut. Mr. Chairman, I yield myself such time as I may consume.

I would like to comment on the amendment. Mr. PRICE has been a very active and fine mind as we developed this bill, and I welcome his amendment.

I do think we need to evaluate new methodologies and procedures very carefully; and as a physician, he brings to this issue a lot of information and a lot of concern about both advances and also problems that could develop.

I will say one of the strengths of the bill that has not been talked about on the floor here today is that it does move us to the ICD 10 system from the ICD 9 system, and that will give us a great deal more ability to look at quality, to judge quality, to pay for quality, to analyze actually what series of symptoms responded best to precisely what treatment approach.

But there are also shoals in every water, and I think your study is very appropriate. The ICD 10 system is now not only more glandular, but we also think it will help us to reduce fraud and abuse. But no matter how many positive things we think it will contribute, it is also wise to know and watch for and evaluate whether or not it is creating problems that we did not anticipate.

So I welcome this study, and I thank Mr. PRICE for his contribution.

Mr. Chairman, I yield back the balance of my time.

Mr. PRICE of Georgia. Mr. Chairman, I yield myself such time as I may consume.

I appreciate those comments, and I would agree, I think it is important that we move forward with a more specific ICD coding system. ICD 10 will do that, and hopefully it will be adopted in a timely fashion.

This report will be back prior to the installation of those new codes, and so I look forward to seeing the results of this report and hopefully making some recommendation at that time, and urge my colleagues to support this amendment.

Mr. Chairman, I yield back the balance of my time.

The CHAIRMAN. The question is on the amendment offered by the gentleman from Georgia (Mr. PRICE).

The amendment was agreed to.

AMENDMENT NO. 6 OFFERED BY MISS MCMORRIS

The CHAIRMAN. It is now in order to consider amendment No. 6 printed in part C of House Report 109–603.

Miss MCMORRIS. Mr. Chairman, I offer an amendment.

The CHAIRMAN. The Clerk will designate the amendment.

The text of the amendment is as follows:

Amendment No. 6 offered by Miss MCMORRIS:

At the end of title IV, insert the following new section:

SEC. 409. PROMOTING HEALTH INFORMATION TECHNOLOGY AS A TOOL FOR CHRONIC DISEASE MANAGEMENT.

(a) IN GENERAL.—The Secretary of Health and Human Services shall establish a two-year project to demonstrate the impact of health information technology on disease management for individuals entitled to medical assistance under a State plan under title XIX of the Social Security Act.

(b) STRUCTURE OF PROJECT.—The project under subsection (a) shall—

(1) create a web-based virtual case management tool that provides access to best practices for managing chronic disease; and

(2) provide chronic disease patients and caregivers access to their own medical records and to a single source of information on chronic disease.

(c) COMPETITION.—Not later than the date that is 90 days after the date of the enactment of this Act, the Secretary of Health and Human Services shall seek proposals from States to carry out the project under subsection (a). The Secretary shall select not less than four of such proposals submitted, and at least one proposal selected shall include a regional approach that features access to an integrated hospital information system in at least two adjoining States and that permits the measurement of health outcomes.

(d) REPORT.—Not later than the date that is 90 days after the last day of the project under subsection (a), the Secretary of Health and Human Services shall submit to Congress a report on such project and shall include in such report the amount of any cost-savings resulting from the project and such recommendations for legislation or administrative action as the Secretary determines appropriate.

The CHAIRMAN. Pursuant to House Resolution 952, the gentlewoman from

Washington (Miss MCMORRIS) and a Member opposed each will control 5 minutes.

The Chair recognizes the gentlewoman from Washington.

Miss MCMORRIS. Mr. Chairman, I yield myself as much time as I may consume.

I rise to offer the McMorris-Smith MAP IT amendment, the Medicaid Access Project through Information Technology proposal. This amendment is supported by the Healthcare Information and Management Systems, the Society Information Technology Industry Council, the American Health Information Management Association, the American Hospital Association, the Federation of American Hospitals, the American Medical Association, and the U.S. Chamber of Commerce.

The McMorris-Smith amendment and the underlying bill will help fulfill President Bush's goal of most Americans having an electronic health record by the year 2014.

I am pleased to offer this bipartisan amendment which strengthens the Health Information Technology Promotion Act and its goal of encouraging the adoption of health information technology into our health care system. As I have traveled throughout eastern Washington, I have seen the need for health information technology and the potential that it has not just to improve health care delivery but also save costs.

Information technology has the power to revolutionize the delivery of health care. This bill is a first step toward encouraging the utilization of health IT on a national level, and I applaud the efforts of Chairman DEAL and Chairman JOHNSON for leading this effort.

This bill represents collaboration between health care providers, payers, patient advocates and the IT community and will pave the way for better access to quality health care for Americans.

As we move forward to set these new standards in place, it is crucial that we take steps to include health information technology in government-funded health programs like Medicare and Medicaid. Health information technology will increase effectiveness, efficiency, overall quality, and promote cost savings in the long run.

This amendment strengthens the underlying bill by incorporating a Web-based tool to manage chronic disease populations within Medicaid. This provision will allow for the creation of a virtual case management program that provides patients and providers access to a real-time electronic medical record. We need to seriously study the effects of using health IT to better serve patients and taxpayers.

Modest estimates show that medical errors cause around 400,000 avoidable injuries and fatalities annually and more than 800,000 in elderly care centers and over a half a million befall Medicare patients in outpatient care. The cost incurred from correcting and treating medication-related errors occurring in hospitals, not counting doctors' offices and other facilities, was projected to be at least $3.5 billion annually. These staggering numbers can and should change.

The United States spends more than 2½ times any other country on health care. We need to ensure that we are maximizing our resources and getting a high return on our investment. A study published in August of 2005 by the Institute for Public Policy and Economic Analysis at Eastern Washington University found that for every dollar spent on a technology-enabled disease management program, it provided up to $10 in medical savings and even more in terms of nonmedical cost savings. At a time when most States are facing increased taxes or cutting Medicaid benefits, increasing outcomes and cutting costs is a win-win situation.

The McMorris-Smith amendment would allow us to more fully study the cost savings and patient benefits of utilizing health information technology within one of Medicaid's most costly populations, chronic disease sufferers. Any piece of comprehensive health information technology legislation must help address the cost and care of this population that consumes 80 percent of the Medicaid resources, yet that is just 20 percent of the Medicaid population.

We can address this issue. This amendment takes savings and quality theories and provides a vehicle for practical application now.

Thank you for your consideration. I urge Members to adopt the McMorris-Smith amendment and support the underlying bill.

Mr. Chairman, I reserve the balance of my time.

The CHAIRMAN. Who claims time in opposition to the amendment?

Mr. SMITH of Washington. Mr. Chairman, I am not in opposition to the amendment, but I would claim the time unless somebody is.

The CHAIRMAN. Without objection, the gentleman from Washington will control the time in opposition.

There was no objection.

Mr. SMITH of Washington. Mr. Chairman, I yield to myself as much time as I may consume.

I want to thank Representative MCMORRIS for her leadership on this bipartisan issue.

This amendment really gets at the heart of why health care information technology is important in the first place, and there are really two big reasons. Number one, it can significantly improve the quality of care for patients; and, number two, it can significantly reduce health care inflation. Right now, if you want to do anything to improve the quality of health care in this country getting inflation under control is job one so that people can access that.

That is what health care information technology has the promise to do; and this amendment, in particular, focuses on one aspect of it where it could really reduce the costs and improve the quality of care, helping a specific class of patients get the best information possible for the best disease management possible.

All across the world, information is being developed even as we sit here on how to better deal with all kinds of different diseases. But how do we make sure that both patients and providers have real-time access to that best information and employ it? That is what this amendment aims to do. For diabetes patients with Medicaid, it can give us a real case example of how we can save money and improve the quality of care for these patients.

I think there is unbelievable potential if we have the best information possible. Too often now patients do not know what the best care is. Too often providers do not even know at the moment what the best care is; and as a consequence, they do not get it and the patients do not receive it. Health care quality goes down and costs go up, as procedures are either repeated or the wrong procedures are done.

This amendment gives us a great opportunity to do an isolated case study on how to make this work in disease management to improve the quality of care and get costs under control.

Mr. Chairman, I reserve the balance of my time.

Miss MCMORRIS. Mr. Chairman, I yield 30 seconds to the gentleman from Pennsylvania (Mr. MURPHY), my friend.

Mr. MURPHY. Mr. Chairman, I thank the gentlewoman for putting this important amendment in.

Previously, it has been cited that the CBO report did not show a savings. Let me mention three things that chronic care management does. 300,000 asthmatic children were studied with chronic care and found that lowered rehospitalization by 34 percent. University of Pittsburgh Medical Center reduced rehospitalization of diabetics by 75 percent. Washington Hospital, Washington, PA, reduced rehospitalization of chronic heart disease by 50 percent.

I suggest the CBO look at how electronic medical records can save money in this.

I have listed a lot of these things in a report entitled, ''Critical Condition, the State of the Union's Health Care,'' which I have available at my Web site; and I urge my colleagues to look at that, and I urge the CBO to read it as well. They might learn something.

Mr. SMITH of Washington. Mr. Chairman, I yield 1 minute to the gentlewoman from Illinois (Ms. BEAN).

Ms. BEAN. Mr. Chairman, I rise in strong support of this Smith-McMorris amendment to establish a 2-year health IT demonstration project for Medicaid patients with chronic diseases.

This bill is a step in the right direction, but the Smith-McMorris amendment would actually speed the implementation of health IT in a crucial and tangible way. It will not only improve efficiency and quality, but will also

help control the growing costs for Medicaid patients with chronic health conditions.

Mr. Chairman, these patients often have complex medical conditions, relying on multiple doctors and numerous medications.

This amendment would put patients in better control of their medical information, provide improved access and more information for caregivers, and create a Web-based resource to promote best practices for chronic care management.

Mr. Chairman, the need for health IT is well established and will both save lives and billions of dollars. This body talks often about the need to improve quality of care and reduce inefficient spending under Medicaid. The Smith-McMorris amendment promises us an opportunity to move beyond rhetoric and actually better care and more responsible return on our tax dollars.

□ 1500

Mr. SMITH of Washington. Mr. Chairman, may I inquire how much time I have left.

The CHAIRMAN. The gentleman has 2½ minutes remaining.

Mr. SMITH of Washington. Mr. Chairman, I yield myself 15 seconds to close and to once again thank Representative MCMORRIS and to point out how important chronic disease management is in saving money. This is an outstanding opportunity for us to use technology to do that, and I urge adoption of the amendment.

Mr. Chairman, I yield the balance of my time to Representative MCMORRIS.

Miss MCMORRIS. Mr. Chairman, I yield my good friend from South Carolina (Mr. WILSON) 1 minute.

Mr. WILSON of South Carolina. I want to congratulate Congresswoman MCMORRIS on her leadership with Congressman SMITH on this issue.

As a person who has a son who is a doctor in California, I am very grateful to be here and support the amendment, which will create a Web-based virtual case management tool that provides access to the best practices for managing chronic disease.

Additionally, this amendment would provide for chronic disease patients and caregivers to have access to their own medical records and to a single source of information on chronic disease.

Further, it directs the Secretary to select at least four proposals from those submitted by States and at least one proposal selected to include a regional approach featuring access to an integrated hospital information system in at least two adjoining States that permits the measurement of outcomes.

I know personally that our family has benefited from the best of health care. One of our sons has been a cancer survivor. And I just want to congratulate, again, Congresswoman MCMORRIS on her leadership; and I urge adoption of the amendment.

Miss MCMORRIS. Mr. Chairman, may I inquire as to how much time remains.

The CHAIRMAN. The gentlewoman has 1¾ minutes remaining.

Miss MCMORRIS. Mr. Chairman, I yield 1 minute to my good friend from Georgia (Mr. GINGREY).

Mr. GINGREY. Mr. Chairman, I am very happy to rise in support of the amendment of the gentlewoman from Washington. A little disappointed my own great amendments were not made in order but very happy to support hers.

As a physician, having practiced 30 years of clinical medicine, there is no question that the cost of chronic disease management is the most costly, and particularly under Medicaid. I think the gentlewoman has the exact right idea, to be able to monitor this information on a real-time basis so that physicians know exactly what they are spending and what is cost effective.

I was very happy as a member of the Rules Committee to recommend her amendment be made in order. Thank goodness it was, and I proudly stand here today to recommend this amendment to all of my colleagues on both sides of the aisle. I commend her for the good job she has done.

Miss MCMORRIS. Mr. Chairman, I yield to the great chairman of the subcommittee who, without her support, we would not be having this amendment before us today.

Mrs. JOHNSON of Connecticut. Mr. Chairman, I rise in strong support of this amendment. First of all, of all the systems in America that really need this kind of attention, it is our Medicaid system because they deal mostly with elderly and poor whose health has long been neglected.

So I know this is going to give us a lot of very good insight and information into how we can both improve the quality and reduce the cost of care in our Medicaid system, and I congratulate the gentlewoman and her cosponsors for bringing this before us today.

Miss MCMORRIS. Mr. Chairman. I yield back the balance of my time.

The CHAIRMAN. The question is on the amendment offered by the gentlewoman from Washington (Miss MCMORRIS).

The amendment was agreed to.

AMENDMENT NO. 2 OFFERED BY MR. TOWNS

The CHAIRMAN. Pursuant to clause 6 of rule XVIII, the pending business is the demand for a recorded vote on the amendment offered by the gentleman from New York (Mr. TOWNS) on which further proceedings were postponed and on which the ayes prevailed by voice vote.

The Clerk will redesignate the amendment.

The Clerk redesignated the amendment.

RECORDED VOTE

The CHAIRMAN. A recorded vote has been demanded.

A recorded vote was ordered.

The vote was taken by electronic device, and there were—ayes 417, noes 1, not voting 14, as follows:

[Roll No. 414]

AYES—417

Abercrombie
Ackerman
Aderholt
Akin
Alexander
Allen
Andrews
Baca
Bachus
Baird
Baker
Baldwin
Barrett (SC)
Barrow
Bartlett (MD)
Barton (TX)
Bass
Bean
Beauprez
Becerra
Berkley
Berman
Berry
Biggert
Bilbray
Bilirakis
Bishop (GA)
Bishop (NY)
Bishop (UT)
Blackburn
Blumenauer
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Boren
Boswell
Boucher
Boustany
Boyd
Bradley (NH)
Brady (PA)
Brady (TX)
Brown (OH)
Brown (SC)
Brown, Corrine
Brown-Waite, Ginny
Burgess
Burton (IN)
Butterfield
Buyer
Calvert
Camp (MI)
Campbell (CA)
Cannon
Cantor
Capito
Capps
Capuano
Cardin
Cardoza
Carnahan
Carson
Carter
Case
Castle
Chabot
Chandler
Chocola
Clay
Cleaver
Coble
Cole (OK)
Conaway
Conyers
Cooper
Costa
Costello
Cramer
Crenshaw
Cuellar
Culberson
Cummings
Davis (AL)
Davis (CA)
Davis (FL)
Davis (IL)
Davis (KY)
Davis (TN)
Davis, Tom
DeFazio
DeGette
Delahunt
DeLauro
Dent
Diaz-Balart, L.
Diaz-Balart, M.
Dicks
Dingell
Doggett
Doolittle
Doyle
Drake
Dreier
Duncan
Edwards
Ehlers
Emanuel
Emerson
Engel
English (PA)
Eshoo
Etheridge
Farr
Fattah
Feeney
Ferguson
Filner
Fitzpatrick (PA)
Flake
Foley
Forbes
Ford
Fortenberry
Foxx
Frank (MA)
Franks (AZ)
Frelinghuysen
Gallegly
Garrett (NJ)
Gerlach
Gibbons
Gilchrest
Gillmor
Gingrey
Gohmert
Gonzalez
Goode
Goodlatte
Gordon
Granger
Graves
Green (WI)
Green, Al
Green, Gene
Grijalva
Gutierrez
Gutknecht
Hall
Harman
Harris
Hart
Hastings (FL)
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Herger
Herseth
Higgins
Hinchey
Hinojosa
Hobson
Hoekstra
Holden
Honda
Hooley
Hostettler
Hoyer
Hulshof
Hunter
Hyde
Inglis (SC)
Inslee
Israel
Issa
Jackson (IL)
Jackson-Lee (TX)
Jefferson
Jenkins
Jindal
Johnson (CT)
Johnson (IL)
Johnson, E. B.
Johnson, Sam
Jones (NC)
Jones (OH)
Kanjorski
Kaptur
Keller
Kelly
Kennedy (MN)
Kennedy (RI)
Kildee
Kilpatrick (MI)
Kind
King (IA)
King (NY)
Kingston
Kirk
Kline
Knollenberg
Kolbe
Kucinich
Kuhl (NY)
LaHood
Langevin
Lantos
Larsen (WA)
Larson (CT)
Latham
LaTourette
Leach
Lee
Levin
Lewis (CA)
Lewis (KY)
Linder
Lipinski
LoBiondo
Lofgren, Zoe
Lowey
Lucas
Lungren, Daniel E.
Lynch
Mack
Maloney
Manzullo
Marchant
Markey
Marshall
Matheson
Matsui
McCarthy
McCaul (TX)
McCollum (MN)
McCotter
McCrery
McDermott
McGovern
McHenry
McHugh
McIntyre
McKeon
McMorris
McNulty
Meehan
Meek (FL)
Meeks (NY)
Melancon
Mica
Michaud
Miller (FL)
Miller (MI)
Miller (NC)
Miller, Gary
Miller, George
Mollohan
Moore (KS)
Moore (WI)
Moran (KS)
Moran (VA)
Murphy
Murtha
Musgrave
Myrick
Nadler
Napolitano
Neal (MA)
Neugebauer
Ney
Northup
Norwood
Nunes
Nussle
Oberstar
Obey
Olver
Ortiz
Osborne
Otter

Owens
Oxley
Pallone
Pascrell
Pastor
Payne
Pearce
Pelosi
Pence
Peterson (MN)
Peterson (PA)
Petri
Pickering
Pitts
Platts
Poe
Pombo
Pomeroy
Porter
Price (GA)
Price (NC)
Pryce (OH)
Putnam
Radanovich
Rahall
Ramstad
Rangel
Regula
Rehberg
Reichert
Renzi
Reyes
Reynolds
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Ross
Rothman
Roybal-Allard
Royce
Ruppersberger
Rush
Ryan (OH)
Ryan (WI)
Ryun (KS)
Sabo
Salazar
Sánchez, Linda T.
Sanchez, Loretta
Sanders
Saxton
Schakowsky
Schiff
Schmidt
Schwartz (PA)
Schwarz (MI)
Scott (GA)
Scott (VA)
Sensenbrenner
Serrano
Sessions
Shadegg
Shaw
Shays
Sherman
Sherwood
Shimkus
Shuster
Simmons
Simpson
Skelton
Slaughter
Smith (NJ)
Smith (TX)
Smith (WA)
Snyder
Sodrel
Solis
Souder
Spratt
Stark
Stearns
Strickland
Stupak
Sullivan
Sweeney
Tancredo
Tanner
Tauscher
Taylor (MS)
Taylor (NC)
Terry
Thomas
Thompson (CA)
Thompson (MS)
Thornberry
Tiahrt
Tiberi
Tierney
Towns
Turner
Udall (CO)
Udall (NM)
Upton
Van Hollen
Velázquez
Visclosky
Walden (OR)
Walsh
Wamp
Wasserman Schultz
Waters
Watson
Watt
Waxman
Weiner
Weldon (FL)
Weldon (PA)
Weller
Westmoreland
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Woolsey
Wu
Wynn
Young (AK)
Young (FL)

NOES—1

Paul

NOT VOTING—14

Clyburn
Crowley
Cubin
Davis, Jo Ann
Deal (GA)
Evans
Everett
Fossella
Holt
Istook
Lewis (GA)
McKinney
Millender-McDonald
Wexler

□ 1529

Messrs. WELDON of Florida, CUMMINGS, and INSLEE changed their vote from ''no'' to ''aye.''

So the amendment was agreed to.

The result of the vote was announced as above recorded.

The CHAIRMAN. Under the rule, the Committee rises.

Accordingly, the Committee rose; and the Speaker pro tempore (Mr. FEENEY) having assumed the chair, Mr. SIMPSON, Chairman of the Committee of the Whole House on the State of the Union, reported that that Committee, having had under consideration the bill (H.R. 4157) to amend the Social Security Act to encourage the dissemination, security, confidentiality, and usefulness of health information technology, pursuant to House Resolution 952, he reported the bill, as amended pursuant to that rule, back to the House with further sundry amendments adopted by the Committee of the Whole.

The SPEAKER pro tempore. Under the rule, the previous question is ordered.

Is a separate vote demanded on any amendment? If not, the Chair will put them en gros.

The amendments were agreed to.

The SPEAKER pro tempore. The question is on the engrossment and third reading of the bill.

The bill was ordered to be engrossed and read a third time, and was read the third time.

MOTION TO RECOMMIT OFFERED BY MR. DOGGETT

Mr. DOGGETT. Mr. Speaker, I have a motion to recommit at the desk.

The SPEAKER pro tempore. Is the gentlemen opposed to the bill?

Mr. DOGGETT. I certainly am, Mr. Speaker.

The SPEAKER pro tempore. The Clerk will report the motion to recommit.

The Clerk read as follows:

Mr. Doggett moves to recommit the bill H.R. 4157 to the Committees on Energy and Commerce and Ways and Means with instructions to report the same back to the House forthwith with the following amendment:

Amend section 205 to read as follows:

SEC. 205. PRIVACY AND SECURITY PROTECTIONS.

(a) IN GENERAL.—The Secretary of Health and Human Services shall provide for standards for health information technology (as such term is used in this Act) that include the following privacy and security protections:

(1) Except as provided in succeeding paragraphs, each entity must—

(A) expressly recognize the individual's right to privacy and security with respect to the electronic disclosure of such information;

(B) permit individuals to exercise their right to privacy and security in the electronic disclosure of such information to another entity by obtaining the individual's written or electronic informed consent, which consent may authorize multiple disclosures; and

(C) permit an individual to prohibit access to certain categories of individuals (as defined by the Secretary) of particularly sensitive information, including data relating to infection with the human immunodeficiency virus (HIV), to mental health, to sexually transmitted diseases, to reproductive health, to domestic violence, to substance abuse treatment, to genetic testing or information, to diabetes, and other information as defined by the Secretary after consent has been provided under subparagraph (B).

(2) Informed consent may be inferred, in the absence of a contrary indication by the individual—

(A) to the extent necessary to provide treatment and obtain payment for health care in emergency situations;

(B) to the extent necessary to provide treatment and payment where the health care provider is required by law to treat the individual;

(C) if the health care provider is unable to obtain consent due to substantial barriers to communicating with the individual and the provider reasonably infers from the circumstances, based upon the exercise of professional judgment, that the individual does not object to the disclosure or that the disclosure is in the best interest of the individual; and

(D) to the extent that the information is necessary to carry out or otherwise implement a medical practitioner's order or prescription for health services, medical devices or supplies, or pharmaceuticals.

(3) The protections must prohibit the improper use and disclosure of individually identifiable health information by any entity.

(4) The protections must provide any individual a right to obtain damages and other relief against any entity for the entity's improper use or disclosure of individually identifiable health information.

(5) The protections must require the use of reasonable safeguards, including audit capabilities, encryption and other technologies that make data unusable to unauthorized persons, and other measures, against the risk of loss or unauthorized access, destruction, use, modification, or disclosure of individually identifiable health information.

(6) The protections must provide for notification to any individual whose individually identifiable health information has been lost, stolen, or used for an unauthorized purpose by the entity responsible for the information and notification by the entity to the Secretary.

(b) LIST OF ENTITIES.—The Secretary shall maintain a public list identifying entities whose health information has been lost, stolen, or used in an unauthorized purpose as described in subsection (a)(6) and how many patients were affected by such action.

(c) CONSTRUCTION.—Nothing in this section shall be construed as superseding, altering, or affecting (in whole or in part) any statute, regulation, order, or interpretation in effect in any State that affords any person privacy and security protections greater than that the privacy and security protections described in subsection (a), as determined by the Secretary.

Mr. DOGGETT (during the reading). Mr. Speaker, I ask unanimous consent that the motion to recommit be considered as read and printed in the RECORD.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Texas?

There was no objection.

The SPEAKER pro tempore. The gentleman is recognized for 5 minutes.

Mr. DOGGETT. Mr. Speaker, this is an important motion for a modest bill. It leaves this bill with an opportunity to move forward today with just one important change, and that is the addition of vital personal privacy protection of what should be genuinely personal medical records.

In my youth, there was a popular song called ''I Heard it Through the Grapevine.'' These days, it's ''I saw it on the Internet.'' In this busy world of busy bodies and identity theft and commercial snooping, I believe what a patient confides to a physician about an ailment, what a young couple tells a psychologist about their marriage, what prescription a pharmacist provides, that highly personal information should not be spread and read on the Internet.

The consequences of unwanted disclosure of personal health information is more than embarrassment or humiliation. It may mean the loss of a job or a promotion. It may mean that an individual refuses to confide necessary information to their doctor or avoids health care and critical medical tests because of fear that the information will be disclosed without her consent.

This Administration has shown little interest in personal privacy, whether it was the privacy of library records or phone conversations or veterans' records.

The Federal Government scored a D-plus on the 2005 Computer Security Report Card, with the Departments of Health and Human Services, Veterans Affairs, and Homeland Security scoring an F. And the Administration's record on health care privacy is even worse. As the Post disclosed last month, there have been 19,420 complaints during the Bush Administration about privacy violations. There have, during this Administration, been almost 20,000 complaints about invasions of privacy with medical records, and all of that has not resulted in a single civil fine anywhere in this country under the protections that are available there, and only two criminal cases out of that 20,000.

This is not an adequate performance, and that is why Dr. Deborah Peel, one of my Texas neighbors, and a host of professional and public health organizations have urged us to adopt meaningful privacy protections in this bill.

Mr. Speaker, I yield 1 minute to the gentleman from Rhode Island (Mr. KENNEDY), who has been such an advocate on this.

Mr. KENNEDY of Rhode Island. Mr. Speaker, I want to ask a few questions to my colleagues about this privacy law.

Do you think it should be a violation of Federal health privacy law to be able to hack into an electronic database for health information? I think it should be against the law. But it is not against the law.

If a hospital employee accesses your health record, for example, for a famous movie star and sells it to a tabloid, do you think that is wrong? Well, that is not against the law now. If you can allow a hospital information to be accessible through an information network, this is now permissible.

All of these things are permissible under the HIPAA law. And if you do not like that, you are going to hate what this bill does to HIPAA, which is going to magnify it 100 times. There is going to be no protection for privacy whatsoever.

And that is why I ask all of you to join us in the motion to recommit. Your constituents will thank you for it if you vote for the motion to recommit.

Mr. DOGGETT. Mr. Speaker, I thank the gentleman, and I yield the balance of my time to the gentleman from Massachusetts (Mr. MARKEY), who has led the way on privacy issues across this country.

Mr. MARKEY. Mr. Speaker, I thank the gentleman from Texas for his leadership on this issue.

There is no privacy protection in this bill. We are about to move to an era where all of your drug records, all of your psychiatric records, all of your children's medical records are going online. William Butler Yeats, the great Irish poet, said that in dreams begin responsibility. We have a responsibility to have privacy protections built into this bill.

What do the Republicans say? They say trust the Department of Health and Human Services. This year TOM DAVIS, the Government Reform Committee, gave a grade to all agencies in the protection of privacy. Do you know what grade TOM DAVIS and your Government Reform Committee gave to the Department of Health and Human Services? An F. Now, that is Medicare and Medicaid. That is one quarter of all Americans. Now we are taking all private citizens as well and the Republicans are saying ''trust the Department of Health and Human Services.''

What our motion to recommit says is that every American has the right to say that their children's medical records do not have to be put online; that everyone does not have to know about it; that they have a right to say no, they don't want those records online; that each family can make that decision for themselves.

Vote ''aye'' on the Doggett motion to recommit.

Mr. BARTON of Texas. Mr. Speaker, I rise in opposition to the motion to recommit.

The SPEAKER pro tempore. The gentleman from Texas is recognized for 5 minutes.

Mr. BARTON of Texas. Mr. Speaker, I want to compliment my good friends who have spoken on this motion to recommit. I know all three of the gentlemen, and they are fine fellows and fine public servants and believe passionately in what they speak of. If I were a doctor on this debate, I believe I would have to recommend they take a Valium and just calm down. We do not get this fixed if there is a problem.

Whatever the law is today on medical record privacy, the law is going to be tomorrow on medical record privacy. Nothing in this bill changes that. This is a health information technology bill. We are actually trying to get medical records in our country, the greatest Nation the world has ever known, to use technology that many other industries and many other groups have already incorporated into their daily business routine.

Now, there is an ongoing study at HHS on privacy. They have received over 50,000 public comments so far. This bill before us, if it becomes law, has an implementation period. There is going to be adequate time to come back, if we need to, with a specific medical technology privacy bill.

In past Congresses, Mr. MARKEY and I have been co-chairmen of the Privacy Caucus in the House, along with Senator SHELBY and Senator DODD in the Senate. I am as strong an advocate of protecting personal privacy as anybody in this body. I would say Mr. MARKEY and others share the passion just as strongly as I do.

The bill before us today is not a privacy bill. This motion to recommit is a privacy amendment. We should reject it and then move the underlying bill. And if and when we need to address medical privacy as a stand-alone issue, there will be adequate time and adequate resources devoted to that.

Mr. KENNEDY of Rhode Island. Mr. Speaker, will the gentleman yield?

Mr. BARTON of Texas. I yield to the gentleman from Rhode Island.

Mr. KENNEDY of Rhode Island. Companies that are in the business of storing patient health information online are not covered under HIPAA. Are not covered under HIPAA.

Mr. BARTON of Texas. Mr. Speaker, reclaiming my time, they are covered under adequate laws, and HIPAA is the medical privacy law.

Please vote against the motion to recommit.

Mr. Speaker, I yield the balance of my time to the subcommittee chairman from the Ways and Means Committee, who has worked so tirelessly on this bill, Mrs. JOHNSON of Connecticut.

Mrs. JOHNSON of Connecticut. Mr. Speaker, remember, adoption of HIPAA was a multi-year process, very controversial, very difficult, 50,000 comments just on the regulations.

The SPEAKER pro tempore. The gentlewoman will suspend.

In debate on a motion to recommit, time is not controlled. Therefore, although the gentleman may yield as he pleases, he must remain on his feet.

Mr. BARTON of Texas. I know the rules. I'm supposed to be standing up. I apologize.

Mrs. JOHNSON of Connecticut. My legislation explicitly does not change HIPAA.

The behavior described of hacking in and revealing what would be under HIPAA is a fine of $250,000 and 10 years in jail. So HIPAA is there. It protects our privacy.

What this bill does is to put in place a study to look at what has happened in the States, what has happened between State law and Federal law, to look and see if there are things that need to be done to create greater commonality amongst all these laws so that the nationwide interoperable health information system will protect health information to the current or a higher standard. So in the bill it has to be to a higher standard. But we maintain current law. There is absolute protection.

And, remember, this specific approach was rejected by Donna Shalala and President Clinton; so do not take this vote lightly, folks. What you are voting for is a radical change in a law that is terribly important to all of us and we maintain in this bill.

Mr. BARTON of Texas. Mr. Speaker, I yield back the balance of my time.

The SPEAKER pro tempore. Without objection, the previous question is ordered on the motion to recommit.

There was no objection.

The SPEAKER pro tempore. The question is on the motion to recommit.

The question was taken; and the Speaker pro tempore announced that the noes appeared to have it.

RECORDED VOTE

Mr. DOGGETT. Mr. Speaker, I demand a recorded vote.

A recorded vote was ordered.

The SPEAKER pro tempore. Pursuant to clause 8 and clause 9 of rule XX, this 15-minute vote on the motion to recommit will be followed by 5-minute votes on passage of H.R. 4157, if ordered, and the motion to instruct on H.R. 2830.

The vote was taken by electronic device, and there were—ayes 198, noes 222, not voting 12, as follows:

[Roll No. 415]

AYES—198

Abercrombie
Ackerman
Allen
Andrews
Baca
Baird
Baldwin
Barrow
Bean
Becerra
Berkley
Berman
Berry
Bishop (GA)
Bishop (NY)
Blumenauer
Boren
Boswell
Boucher
Boyd
Brady (PA)
Brown (OH)
Brown, Corrine
Butterfield
Capps
Capuano
Cardin
Cardoza
Carnahan
Carson
Case
Chandler
Clay
Cleaver
Conyers
Costa
Costello
Cramer
Cuellar
Cummings
Davis (AL)
Davis (CA)
Davis (FL)
Davis (IL)
Davis (TN)
DeFazio
DeGette
Delahunt
DeLauro
Dicks
Dingell
Doggett
Doyle
Edwards
Emanuel
Engel
Eshoo
Etheridge
Farr
Fattah
Filner
Ford
Frank (MA)
Gonzalez
Gordon
Green, Al
Green, Gene
Grijalva
Gutierrez
Harman
Hastings (FL)
Herseth
Higgins
Hinchey
Hinojosa
Holden
Holt
Honda
Hooley
Hoyer
Inslee
Israel
Jackson (IL)
Jackson-Lee (TX)
Jefferson
Johnson, E. B.
Jones (NC)
Jones (OH)
Kanjorski
Kaptur
Kennedy (RI)
Kildee
Kilpatrick (MI)
Kind
Kucinich
Langevin
Lantos
Larsen (WA)
Larson (CT)
Lee
Levin
Lipinski
Lofgren, Zoe
Lowey
Lynch
Maloney
Markey
Marshall
Matheson
Matsui
McCarthy
McCollum (MN)
McDermott
McGovern
McIntyre
McNulty
Meehan
Meek (FL)
Meeks (NY)
Melancon
Michaud
Millender-McDonald
Miller (NC)
Miller, George
Mollohan
Moore (KS)
Moore (WI)
Moran (VA)
Murtha
Nadler
Napolitano
Neal (MA)
Oberstar
Obey
Olver
Ortiz
Otter
Owens
Pallone
Pascrell
Pastor
Paul
Payne
Pelosi
Peterson (MN)
Pomeroy
Price (NC)
Rahall
Rangel
Reyes
Ross
Rothman
Roybal-Allard
Ruppersberger
Rush
Ryan (OH)
Sabo
Salazar
Sánchez, Linda T.
Sanchez, Loretta
Sanders
Schakowsky
Schiff
Schwartz (PA)
Scott (GA)
Scott (VA)
Serrano
Sherman
Skelton
Slaughter
Smith (WA)
Snyder
Solis
Spratt
Stark
Strickland
Stupak
Tanner
Tauscher
Taylor (MS)
Thompson (CA)
Thompson (MS)
Tierney
Towns
Udall (CO)
Udall (NM)
Van Hollen
Velázquez
Visclosky
Wasserman Schultz
Waters
Watson
Watt
Waxman
Weiner
Woolsey
Wu
Wynn

NOES—222

Aderholt
Akin
Alexander
Bachus
Baker
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Biggert
Bilbray
Bilirakis
Bishop (UT)
Blackburn
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Boustany
Bradley (NH)
Brady (TX)
Brown (SC)
Brown-Waite, Ginny
Burgess
Burton (IN)
Buyer
Calvert
Camp (MI)
Campbell (CA)
Cannon
Cantor
Capito
Carter
Castle
Chabot
Chocola
Coble
Cole (OK)
Conaway
Cooper
Crenshaw
Culberson
Davis (KY)
Davis, Tom
Dent
Diaz-Balart, L.
Diaz-Balart, M.
Doolittle
Drake
Dreier
Duncan
Ehlers
Emerson
English (PA)
Everett
Feeney
Ferguson
Fitzpatrick (PA)
Flake
Foley
Forbes
Fortenberry
Foxx
Franks (AZ)
Frelinghuysen
Gallegly
Garrett (NJ)
Gerlach
Gibbons
Gilchrest
Gillmor
Gingrey
Gohmert
Goode
Goodlatte
Granger
Graves
Green (WI)
Gutknecht
Hall
Harris
Hart
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Herger
Hobson
Hoekstra
Hostettler
Hulshof
Hunter
Hyde
Inglis (SC)
Issa
Jenkins
Jindal
Johnson (CT)
Johnson (IL)
Johnson, Sam
Keller
Kelly
Kennedy (MN)
King (IA)
King (NY)
Kingston
Kirk
Kline
Knollenberg
Kolbe
Kuhl (NY)
LaHood
Latham
LaTourette
Leach
Lewis (CA)
Lewis (KY)
Linder
LoBiondo
Lucas
Lungren, Daniel E.
Mack
Manzullo
Marchant
McCaul (TX)
McCotter
McCrery
McHenry
McHugh
McKeon
McMorris
Mica
Miller (FL)
Miller (MI)
Miller, Gary
Moran (KS)
Murphy
Musgrave
Myrick
Neugebauer
Ney
Northup
Norwood
Nunes
Nussle
Osborne
Oxley
Pearce
Pence
Peterson (PA)
Petri
Pickering
Pitts
Platts
Poe
Pombo
Porter
Price (GA)
Pryce (OH)
Putnam
Radanovich
Ramstad
Regula
Rehberg
Reichert
Renzi
Reynolds
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Royce
Ryan (WI)
Ryun (KS)
Saxton
Schmidt
Schwarz (MI)
Sensenbrenner
Sessions
Shadegg
Shaw
Shays
Sherwood
Shimkus
Shuster
Simmons
Simpson
Smith (NJ)
Smith (TX)
Sodrel
Souder
Stearns
Sullivan
Sweeney
Tancredo
Taylor (NC)
Terry
Thornberry
Tiahrt
Tiberi
Turner
Upton
Walden (OR)
Walsh
Wamp
Weldon (FL)
Weldon (PA)
Weller
Westmoreland
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Young (AK)
Young (FL)

NOT VOTING—12

Clyburn
Crowley
Cubin
Davis, Jo Ann
Deal (GA)
Evans
Fossella
Istook
Lewis (GA)
McKinney
Thomas
Wexler

□ 1603

Mr. BOOZMAN changed his vote from ''aye'' to ''no.''

Mr. BLUMENAUER changed his vote from ''no'' to ''aye.''

So the motion to recommit was rejected.

The result of the vote was announced as above recorded.

The SPEAKER pro tempore. The question is on the passage of the bill.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

RECORDED VOTE

Mrs. JOHNSON of Connecticut. Mr. Speaker, I demand a recorded vote.

A recorded vote was ordered.

The SPEAKER pro tempore. This will be a 5-minute vote.

The vote was taken by electronic device, and there were—ayes 270, noes 148, not voting 14, as follows:

[Roll No. 416]

AYES—270

Aderholt
Akin
Alexander
Allen
Bachus
Baird
Baker
Barrett (SC)
Barrow
Bartlett (MD)
Barton (TX)
Bass
Bean
Beauprez
Berkley
Biggert
Bilbray
Bilirakis
Bishop (GA)
Bishop (UT)
Blackburn
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Boren
Boucher
Boustany
Boyd
Bradley (NH)
Brady (TX)
Brown (SC)
Brown-Waite, Ginny
Burgess
Burton (IN)
Buyer
Calvert
Camp (MI)
Campbell (CA)
Cannon
Cantor
Capito
Carnahan
Carson
Carter
Castle
Chabot
Chocola
Clay
Cleaver
Coble
Cole (OK)
Conaway
Cooper
Costa
Cramer
Crenshaw
Cuellar
Culberson
Davis (FL)
Davis (KY)
Davis (TN)
Davis, Tom
DeFazio
Dent
Diaz-Balart, L.
Diaz-Balart, M.
Dicks
Doolittle
Drake
Dreier
Edwards
Ehlers
Emerson
English (PA)
Everett
Feeney
Ferguson
Fitzpatrick (PA)
Foley
Forbes
Fortenberry
Foxx
Franks (AZ)
Frelinghuysen
Gallegly
Gerlach
Gibbons
Gilchrest
Gillmor
Gohmert
Gonzalez
Goode
Goodlatte
Gordon
Granger
Graves
Green (WI)
Gutknecht
Hall
Harman
Harris
Hart
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Herger
Herseth
Hinojosa
Hobson
Hoekstra
Hooley
Hulshof
Hunter
Hyde
Inglis (SC)
Inslee
Israel
Issa
Jenkins
Jindal
Johnson (CT)
Johnson (IL)
Johnson, Sam
Keller
Kelly
Kennedy (MN)
Kind
King (IA)
King (NY)
Kingston
Kirk
Kline
Knollenberg
Kolbe
Kuhl (NY)
LaHood
Larsen (WA)
Latham
LaTourette
Leach
Lewis (CA)
Lewis (KY)
Linder
Lipinski
LoBiondo
Lofgren, Zoe
Lucas
Lungren, Daniel E.
Mack
Manzullo
Marchant
Marshall
Matheson
McCarthy
McCaul (TX)
McCotter
McCrery
McHenry
McHugh
McKeon
McMorris
Meeks (NY)
Melancon
Mica
Miller (FL)
Miller (MI)
Miller, Gary
Moore (KS)
Moran (KS)
Moran (VA)
Murphy
Musgrave
Myrick
Neugebauer
Ney
Northup
Norwood
Nunes
Nussle
Oberstar
Ortiz
Osborne
Oxley
Pearce
Peterson (MN)
Peterson (PA)
Petri
Pickering
Pitts
Platts
Poe
Pombo
Porter
Price (GA)
Pryce (OH)
Putnam
Radanovich
Ramstad
Regula
Rehberg
Reichert
Renzi
Reynolds
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Royce
Ruppersberger
Ryan (WI)
Ryun (KS)
Sabo
Salazar
Sanchez, Loretta
Saxton
Schmidt
Schwartz (PA)
Schwarz (MI)
Sensenbrenner
Sessions
Shadegg
Shaw
Shays
Sherwood
Shimkus
Shuster
Simmons
Simpson
Skelton
Smith (NJ)
Smith (TX)
Smith (WA)
Sodrel
Souder
Stearns
Sullivan
Sweeney
Tancredo
Tauscher
Taylor (NC)
Terry
Thompson (CA)
Thornberry
Tiahrt
Tiberi
Towns
Turner
Udall (CO)
Upton
Walden (OR)
Walsh
Weldon (FL)
Weldon (PA)
Weller
Westmoreland
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Wu
Young (AK)
Young (FL)

NOES—148

Abercrombie
Ackerman
Andrews
Baca
Baldwin
Becerra
Berman
Berry
Bishop (NY)

Blumenauer
Boswell
Brady (PA)
Brown (OH)
Brown, Corrine
Butterfield
Capps
Capuano
Cardin
Cardoza
Case
Chandler
Conyers
Costello
Cummings
Davis (AL)
Davis (CA)
Davis (IL)
DeGette
Delahunt
DeLauro
Dingell
Doggett
Doyle
Duncan
Emanuel
Engel
Eshoo
Etheridge
Farr
Fattah
Filner
Flake
Ford
Frank (MA)
Garrett (NJ)
Gingrey
Green, Al
Green, Gene
Grijalva
Gutierrez
Hastings (FL)
Higgins
Hinchey
Holden
Holt
Honda
Hostettler
Hoyer
Jackson (IL)
Jackson-Lee (TX)
Jefferson
Johnson, E. B.
Jones (NC)
Jones (OH)
Kanjorski
Kaptur
Kennedy (RI)
Kildee
Kilpatrick (MI)
Kucinich
Langevin
Lantos
Larson (CT)
Lee
Levin
Lowey
Lynch
Maloney
Markey
Matsui
McCollum (MN)
McDermott
McGovern
McIntyre
McNulty
Meehan
Meek (FL)
Michaud
Millender-McDonald
Miller (NC)
Miller, George
Mollohan
Moore (WI)
Murtha
Nadler
Napolitano
Neal (MA)
Obey
Olver
Otter
Owens
Pallone
Pascrell
Pastor
Paul
Pelosi
Pomeroy
Price (NC)
Rahall
Rangel
Reyes
Ross
Rothman
Roybal-Allard
Rush
Ryan (OH)
Sánchez, Linda T.
Sanders
Schakowsky
Schiff
Scott (GA)
Scott (VA)
Serrano
Sherman
Slaughter
Snyder
Solis
Spratt
Stark
Strickland
Stupak
Tanner
Taylor (MS)
Thompson (MS)
Tierney
Udall (NM)
Van Hollen
Velázquez
Visclosky
Wamp
Wasserman Schultz
Waters
Watson
Watt
Waxman
Weiner
Woolsey
Wynn

NOT VOTING—14

Clyburn
Crowley
Cubin
Davis, Jo Ann
Deal (GA)
Evans
Fossella
Istook
Lewis (GA)
McKinney
Payne
Pence
Thomas
Wexler

□ 1611

So the bill was passed.

The result of the vote was announced as above recorded.

The title of the bill was amended so as to read: ''A Bill to promote a better health information system.''.

A motion to reconsider was laid on the table.

MOTION TO INSTRUCT CONFEREES ON H.R. 2830, PENSION PROTECTION ACT OF 2005

The SPEAKER pro tempore. The unfinished business is the vote on the motion to instruct on H.R. 2830 offered by the gentleman from California (Mr. GEORGE MILLER) on which the yeas and nays are ordered.

The Clerk will redesignate the motion.

The Clerk redesignated the motion.

The SPEAKER pro tempore. The question is on the motion to instruct.

This will be a 5-minute vote.

The vote was taken by electronic device, and there were—yeas 285, nays 126, not voting 21, as follows:

[Roll No. 417]

YEAS—285

Abercrombie
Aderholt
Allen
Andrews
Baca
Baird
Baldwin
Barrow
Bartlett (MD)
Bean
Becerra
Berkley
Berman
Berry
Bilirakis
Bishop (GA)
Bishop (NY)
Blumenauer
Boehlert
Bonner
Bono
Boozman
Boren
Boswell
Boucher
Boyd
Brady (PA)
Brown (OH)
Brown, Corrine
Brown-Waite, Ginny
Burgess
Butterfield
Calvert
Capito
Capps
Capuano
Cardin
Cardoza
Carnahan
Carson
Carter
Case
Castle
Chandler
Clay
Cleaver
Coble
Conyers
Cooper
Costa
Costello
Cramer
Cuellar
Cummings
Davis (AL)
Davis (CA)
Davis (FL)
Davis (IL)
Davis (KY)
Davis (TN)
Davis, Tom
DeFazio
DeGette
Delahunt
DeLauro
Dent
Dicks
Dingell
Doggett
Doyle
Dreier
Duncan
Edwards
Emerson
Engel
Eshoo
Etheridge
Everett
Farr
Fattah
Ferguson
Filner
Fitzpatrick (PA)
Foley
Forbes
Ford
Fortenberry
Frank (MA)
Gallegly
Gerlach
Gibbons
Gilchrest
Gohmert
Gonzalez
Goode
Gordon
Green (WI)
Green, Al
Green, Gene
Grijalva
Gutknecht
Harman
Hart
Hastings (FL)
Herseth
Higgins
Hinchey
Hinojosa
Holden
Holt
Honda
Hooley
Hostettler
Hoyer
Hunter
Hyde
Inslee
Israel
Jackson (IL)
Jackson-Lee (TX)
Jefferson
Jenkins
Jindal
Johnson (IL)
Johnson, E. B.
Jones (NC)
Jones (OH)
Kanjorski
Kaptur
Kelly
Kennedy (MN)
Kennedy (RI)
Kildee
Kilpatrick (MI)
Kind
King (NY)
Kingston
Kirk
Kucinich
Kuhl (NY)
LaHood
Langevin
Lantos
Larsen (WA)
LaTourette
Leach
Lee
Levin
Lipinski
LoBiondo
Lofgren, Zoe
Lowey
Lynch
Maloney
Manzullo
Markey
Marshall
Matheson
Matsui
McCarthy
McCollum (MN)
McCotter
McDermott
McGovern
McHugh
McIntyre
McNulty
Meehan
Meek (FL)
Meeks (NY)
Michaud
Millender-McDonald
Miller (MI)
Miller (NC)
Miller, George
Mollohan
Moore (KS)
Moore (WI)
Moran (KS)
Moran (VA)
Murphy
Murtha
Nadler
Napolitano
Neal (MA)
Ney
Nussle
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor
Paul
Pelosi
Peterson (MN)
Pickering
Platts
Poe
Pombo
Pomeroy
Porter
Price (NC)
Rahall
Ramstad
Rangel
Regula
Rehberg
Reichert
Renzi
Reyes
Rogers (MI)
Rohrabacher
Ross
Rothman
Roybal-Allard
Royce
Ruppersberger
Rush
Ryan (OH)
Sabo
Salazar
Sánchez, Linda T.
Sanchez, Loretta
Sanders
Saxton
Schakowsky
Schiff
Schmidt
Schwartz (PA)
Schwarz (MI)
Scott (GA)
Scott (VA)
Serrano
Shaw
Shays
Sherman
Sherwood
Simmons
Skelton
Slaughter
Smith (NJ)
Smith (WA)
Snyder
Sodrel
Solis
Souder
Stark
Stupak
Sullivan
Sweeney
Tancredo
Tanner
Tauscher
Taylor (MS)
Taylor (NC)
Thompson (CA)
Thompson (MS)
Tierney
Towns
Turner
Udall (CO)
Udall (NM)
Upton
Van Hollen
Velázquez
Visclosky
Walsh
Wamp
Wasserman Schultz
Waters
Watson
Watt
Waxman
Weiner
Weldon (PA)
Weller
Wilson (NM)
Wolf
Woolsey
Wu
Wynn
Young (FL)

NAYS—126

Akin
Alexander
Bachus
Baker
Barrett (SC)
Barton (TX)
Bass
Beauprez
Biggert
Bilbray
Bishop (UT)
Blackburn
Blunt
Boehner
Bonilla
Boustany
Bradley (NH)
Brady (TX)
Brown (SC)
Burton (IN)
Buyer
Camp (MI)
Campbell (CA)
Cannon
Cantor
Chabot
Chocola
Cole (OK)
Conaway
Crenshaw
Culberson
Diaz-Balart, L.
Diaz-Balart, M.
Doolittle
Drake
Ehlers
English (PA)
Feeney
Flake
Foxx
Franks (AZ)
Frelinghuysen
Garrett (NJ)
Gillmor
Gingrey
Goodlatte
Granger
Graves
Hall
Harris
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Herger
Hobson
Hulshof
Inglis (SC)
Issa
Johnson (CT)
Johnson, Sam
Keller
King (IA)
Kline
Knollenberg
Kolbe
Latham
Lewis (CA)
Lewis (KY)
Linder
Lucas
Lungren, Daniel E.
Mack
Marchant
McCaul (TX)
McCrery
McHenry
McKeon
McMorris
Mica
Miller (FL)
Miller, Gary
Musgrave
Myrick
Neugebauer
Northup
Norwood
Nunes
Osborne
Otter
Oxley
Pearce
Pence
Peterson (PA)
Petri
Pitts
Price (GA)
Pryce (OH)
Putnam
Radanovich
Reynolds
Rogers (AL)
Rogers (KY)
Ros-Lehtinen
Ryan (WI)
Ryun (KS)
Sensenbrenner
Sessions
Shadegg
Shimkus
Shuster
Simpson
Smith (TX)
Stearns
Terry
Thomas
Tiahrt
Tiberi
Walden (OR)
Weldon (FL)
Westmoreland
Whitfield
Wicker
Wilson (SC)
Young (AK)

NOT VOTING—21

Ackerman
Clyburn
Crowley
Cubin
Davis, Jo Ann
Deal (GA)
Emanuel
Evans
Fossella
Gutierrez
Hoekstra
Istook
Larson (CT)
Lewis (GA)
McKinney
Melancon
Payne
Spratt
Strickland
Thornberry
Wexler

□ 1621

Mr. MARCHANT changed his vote from ''yea'' to ''nay.''

So the motion to instruct was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

AUTHORIZING REPAIR OF MACE OF HOUSE OF REPRESENTATIVES

Mr. BOEHNER. Mr. Speaker, I offer a resolution (H. Res. 957) and I ask unanimous consent for its immediate consideration.

The Clerk read the resolution, as follows:

Resolved,

SECTION 1. REPAIR OF MACE OF HOUSE OF REPRESENTATIVES.

(a) DELIVERY FOR REPAIR.—The Sergeant at Arms of the House of Representatives is authorized and directed, on behalf of the House of Representatives, to deliver the mace of the House of Representatives, following an adjournment of the House pursuant to concurrent resolution, to the Secretary of the Smithsonian Institution only for the purpose of having necessary repairs made to the mace and under such circumstances as will assure that the mace is properly safeguarded.

(b) RETURN.—The mace shall be returned to the House of Representatives before noon on the day before the House next reconvenes pursuant to concurrent resolution or at any sooner time when so directed by the Speaker of the House of Representatives.